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Caring for women with eating disorders – Aspects of the church as part of the problem and part of the solution

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Abstract

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The Royal College of Psychiatrists' special interest group on spirituality has confirmed that religious and spiritual beliefs can be curative in the recovery from various mental health difficulties including eating disorders (Dein et al., 2010). Few studies in the United Kingdom, however. have explored whether and how church communities could contribute to this therapeutic process. This interdisciplinary thesis aims to provide recommendations to assist with the improvement of church-based pastoral care of women experiencing eating disorders, primarily anorexia nervosa and bulimia nervosa, using insights from feminist theology and other relevant sources.

The critical analysis in this thesis has been derived predominantly from feminist theology. However, a theological reflection on the praxis of pastoral care cannot pursue its deliberations in isolation and, consequently. this thesis has used interdisciplinary insight from a variety of perspectives, including social science, psychology, psychoanalysis, philosophy and psychiatry. These insights have facilitated a multi-directional theological reflection on the aetiological, sociocultural and environmental stressors which contribute to eating disorders and have aided the formation of a response from the analysis. As the context of this thesis is in the post-conflict province of Northern Ireland, an exploration of characteristics of religious fundamentalism has been essential to help understand the implicit perceptions which inevitably influence the praxis of pastoral care. With a foundation in practical theology, using the pastoral cycle, this thesis invites the reader into a reflective conversation on how church communities might more effectively care for these women who have often felt disempowered, marginalised and fragmented as a consequence of traumatic experiences.

Unique perspectives have been derived from a thematic analysis of semi-structured interviews with women who have experienced eating disorders, carers of women who

have experienced eating disorders and those claiming insight into both the subject of mental health and the church community. Synthesising the core and subsidiary themes with existing literature has contributed to discussions which have shaped the recommendations. Significantly, many fundamentalist traits mirror the characteristics of women experiencing eating disorders. Therefore, it has been crucial to consider how these traits may deepen distress for the sufferer in pastoral encounters and provide an alternative theological perspective which has potential to help counteract these deleterious effects. Furthermore, the paucity of relevant, theologically-based pastoral care literature on eating disorders has verified the need for additional future research to commence a theologically-based process which could aid in recovery.

Although church communities demonstrate negative factors which are not conducive to recovery, some communities which are receptive to change, could have a distinctive opportunity to offer much-needed stability and safety to women experiencing eating disorders and to their carers. The abandonment of over-intellectualisation in favour of an embodied practice, opens up possibilities for the entire church community to be engaged in compassionate interpersonal relationships to help reduce crippling feelings of shame. More specifically, empowering the one who is suffering to engage with their vulnerability and realise their creative capacity, can open doors to reducing fear through experiencing transcendence and awe within and beyond the immediacy of the pastoral encounter. Through collaboration with systemic, specialist care, those experiencing eating disorders and their carers might discover a unique liberation in the acceptance of their suffering through embodied, present hope in the church community and participate in the relational resurrection of Christ.

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Abbreviations

American Psychiatric Association (APA)

Anorexia Nervosa (AN)

Binge Eating Disorder (BED)

Biologically Based Mental Illness (BBMI)

Bulimia Nervosa (BN)

Cognitive Behavioural Therapy (CBT)

Cognitive Behavioural Therapy Enhanced (CBT-E)

Compassion Focused Therapy (CFT)

Department of Health (DH)

Department of Health and Social Services and Public Safety for Northern Ireland (DHSSPSNI)

Diagnostic and Statistical Manual of Mental Disorders (DSM)

Eating Disorder Association Northern Ireland (EDANI)

Eating Disorders Awareness Week (EDAW)

Eating Disorder Focused Cognitive Behavioural Therapy (CBT-ED)

Eating Disorder Focused Focal Psychodynamic Therapy (FPT)

Eating Disorders (EDs)

Eating Disorders Awareness Week (EDAW)

Health and Social Care Board (HSCB)

Health and Social Care in Northern Ireland (HSCNI)

Interpersonal therapy (IPT)

Maudsley Model of Anorexia Treatment for adults (MANTRA)

Mental Health foundation (MHF)

Mindfulness based Interventions (MBI)

National Health Service (NHS)

Non-Suicidal Self-Injury (NSSI)

Northern Ireland (NI)

Post-traumatic stress disorder (PTSD)

Presbyterian Church Ireland (PCI)

PriceWaterhouseCoopers (PwC)

Public Health Agency (PHA)

Queens University Belfast (QUB)

Randomised Control Trial (RCT)

Regulation and Quality Improvement Authority (RQIA)

Royal College of Psychiatrists (RCP)

Specialist Supportive Clinical Management (SSCM)

Wellness Recovery Action Plan (WRAP)

World Psychiatric Association (WPA)

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Second, I would like to thank my supervisors, Professor Drew Gibson and Dr Anne Campbell for their wisdom and steadfast commitment to guiding me through the past three years. Their capacity to cultivate creativity, and investment in my development has moulded my personhood beyond what I thought was imaginable.

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Dedication

This thesis is dedicated to my parents,

whose boundless love has taught me how to live.

dum vivimus, vivamus, labore et honore

... and to the memory of,

Agnes Ramage,

my grandmother.

Chapter One: The thesis as a critical conversation

1.1 Introduction

The title of this thesis is: 'Caring for women with eating disorders (EDs) – Aspects of the church as part of the problem and part of the solution.' This chapter will outline the research problem and the framework for this thesis. This research critically analyses the condition of having an ED, the context being fundamentalist environments and the challenge of feminist theology in providing a response. However, much of this research is preparatory, due to the lack of ED-specific pastoral care literature and therefore interdisciplinary integration from various research fields, including psychology, social sciences and psychiatry has been crucial. To further this process of interdisciplinary integration, Pattison's (1989) Critical Conversation and Pastoral Cycle, helpfully articulated and explained by Osmer, (among others), have been crucial. Osmer's (2008) methods of theological reflection (TR) have provided a circular, rather than linear, framework for critical conversations throughout the thesis.

1.2 Research problem

The leading National Charity, Beat (PricewaterhouseCoopers Report (PwC), 2015) estimates that more than 725,000 people in the United Kingdom (UK) are affected by an ED. Annually in Northern Ireland (NI) approximately 50-120 people develop anorexia nervosa (AN), 170 people develop bulimia nervosa (BN), there are 100 admissions for ED-related emergency care and 15 individuals are sent to England or the Republic of Ireland to obtain specialist inpatient treatment (Regulation and Quality Improvement Authority (RQIA), 2015, p.13). Additionally, Betts and Thompson (2017, p.4) explain that "NI has higher levels of mental ill health than any other region in the UK – 1 in 5 adults and around 45,000 children here have a mental health problem at any one time." As mental illness is the single largest cause of ill health and disability in NI, the implications for both quality of life and government finance are substantial (Betts and Thompson, 2017). Although much progress has been made, more effective treatment methods are urgently needed, especially systemic community-based support (Wilson et al., 2015).

Mortality from AN is statistically higher than from any other mental illness (Hoek, 2016). Furthermore, EDs are positioned as the twelfth major cause of disability in young females in

high-income countries (Hoek, 2016). Obviously high mortality rates are likely to be increased, especially in Severe Mental Disorders, where provision of service is not adequate (Lui et al., 2017). According to Beat's nationwide survey, (PwC, 2015) approximately 90% of those experiencing EDs are female, and although EDs can develop at any age, the risk is highest between thirteen and seventeen years of age (The National Institute for Health and Care Excellence (NICE), 2017). Moreover, Beat's survey documents that 63% of all those who experience an ED have suffered a relapse and required subsequent treatment. NICE (2017, p.36) summarises that "[e]ach disorder is associated with poor quality of life, social isolation, and a substantial impact for family members and carers. Eating disorders are long-lasting conditions if they are not treated."

There are various factors which further embed the disorder and cause resistance to treatment, the most obvious being long delays between referral and the commencement of treatment. The RQIA (2015, p.24) explains: "Trusts are required to ensure that patients wait no longer than nine weeks from referral to the commencement of treatment. For psychological therapies, patients should wait no longer than 13 weeks." However, the most recent report in 2017 reveals that none of NI's four Health Trusts is achieving the waiting time targets for individuals experiencing mental health difficulties. According to the Health and Social Care Board, without additional investment, there is a "high risk" of ongoing breaches of the thirteen-week target (BBC, 2016). Most recently, the Department of Health (DH, 2017) recorded that "[o]ver two thirds (69.6%, 176,276) of patients were waiting more than nine weeks for a first consultant-led outpatient appointment at 31st March 2017." In ED treatment, Beat (Waiting Times Survey, 2013) revealed that 30% of those who experienced EDs had to wait longer than eighteen weeks to access outpatient treatment and 40% of all respondents were informed that their body mass index (BMI) wasn't "low enough to access treatment quickly." Therefore, almost half of those seeking help do not receive specialist help unless they starve themselves to a point where they fit within the diagnostic criteria for critical AN. This is despite NICE (2017, p.10) warnings: "Do not use single measures such as BMI or duration of illness to determine whether to offer treatment for an eating disorder." Failure to provide treatment for those experiencing EDs has devastating consequences. Of the 23% of respondents in Beat's survey (2013) who waited longer than six months for

outpatient services, 60% explained that their motivation to engage in treatment diminished significantly because of the length of time they spent on the waiting list.

The financial figures for the care of those experiencing EDs are at an all-time high (Gaurda et al, 2017). Beat's (PwC, 2015, p.9) study suggests:

> Based on prevalence estimates drawn from previous studies, of between 600,000 and 725,000, these costs suggest – assuming a ratio of 1 carer to 1 sufferer – an annual direct financial burden of between £2.6 billion and £3.1 billion on sufferers and carers, total treatment costs to the NHS of between £3.9 billion and £4.6 billion (and, potentially, a further £0.9 – £1.1 billion of private treatment costs) and lost income to the economy of between £6.8 billion and £8 billion.

The NI Assembly (2014) records that inpatient care in NI for EDs cost £289,166 in 2013; the cost of referrals to England for specialised care was £1.218 million. When support is insufficient, in an effort to preserve lives, ED clients must be referred for specialised inpatient care, which means being uprooted from friends and family and sent to England or the Republic of Ireland. Despite the extremity of the costs, these are secondary to the personal impact on the well-being and quality of life of those experiencing EDs and their carers. There is a compelling case for change.

Contextually, it is important to note that NI is statistically the most religious part of the UK (Ashworth and Farthing, 2007). Religious affiliation has had a prominent role in the cultural development of NI, and although church attendance has declined in recent decades (Northern Ireland Statistics and Research Agency, 2011), church/religious affiliation remains a reliable indicator of sociocultural identity. It is difficult to measure the direct and indirect effects of religion on mental health; however, it often acts primarily as an indicator of underlying cultural and sociological identities (Field, 2014). Therefore, despite the mass of research which suggests that religiosity and spirituality are positive factors influencing good mental health (Koenig, 2009; Hill and Pargament, 2003), in a NI context there is evidence to suggest that religiosity does not necessarily have a positive impact on mental health. Notably, there have been transgenerational effects of trauma deriving from 'The Troubles' (Downes et

al., 2013), including increased levels of transgenerational post-traumatic stress disorder (PTSD). Bruce (Marty and Appleby, 1993, p.50) describes a type of "ethno-religious nationalism" in NI that is not fully fundamentalist but "fundamentalist-like", because of its heavy leaning toward politics. The prevalence of fundamentalist traits in NI could be deemed the primary reason for religiosity not providing a healing factor in mental health recovery.

Feminist theologians challenge these fundamentalist-like traits which negatively influence human flourishing and practical care (Graham, 2017). Miller-McLemore (in Dykstra, 2005, p.42) writes: "[a] feminist perspective demands an analysis of structures and ideologies that rank people as inferior or superior according to various traits of human nature, whether gender, sexual orientation, colour, age, physical ability, and so forth." Glaz (1991, p.12) has provocatively observed that the newly critical perception of psychological theories in pastoral theology may include an "impetus to avoid issues of gender." Hence feminists such as Miller-McLemore (in Dykstra, 2005) and Glaz (1991) would advocate retaining psychological analysis in the light of these issues of gender bias. Miller-McLemore (in Dykstra, 2005, p.42) explains that psychological definitions of human nature and fulfilment can be "culture- and consciousness-shaping forces." There is thus a need to utilise the fields of both psychology and social sciences alongside feminist theologies, to challenge the subtle biases of church communities which dismiss too rashly these approaches as individualistic and unhelpful in theological reflection.

Consequently, a critical analysis of aspects of the church as part of the problem and part of the solution could prove helpful in both improving religious practice and making church communities a more inviting and curative environment for the recovery from EDs.

1.3 Theological reflection (TR)

In pastoral TR, theology is invited to connect with practical life and ministry to enable effective praxis. A core concept in TR is the necessity of commencing reflection from a "thick description," a term formulated to encapsulate the concept of viewing a situation from many vantage points (Geertz, 1973, pp.3-30). Interpretations of human behaviour are often explicable from several different aspects in one given circumstance. In an effort to engage in

social analysis through the lens of practical theology, Browning (1991) was among the first to use these kinds of "thick descriptions" of cultural situations. A "thick description" offers substantial information to enable more accurate pastoral reflection. This TR is based upon Kolb's (1985) learning cycle, which is still identified as a notable progression in the academic comprehension of experiential learning. Reflection in practical theology is thus widely accepted as a method and a cyclical model of "experience, exploration, reflection and action" (Ballard and Pritchard, 2006, pp.77-78). Pattison's model of mutual critical correlation between these key areas has been a vital aspect of this research project's theological methodology. This correlation is described by Swinton and Mowat (2016, p.73) as "bringing situations into dialectical conversations with insights from the Christian tradition and perspectives drawn from other sources of knowledge (primarily the social sciences)." This thesis employs both a theologically-based method for TR, mainly derived from Osmer's (2008) explanation of the Pastoral Cycle and Pattison's (1989) Critical Conversation, and a social science-based methodology. Further information on the theory of practice can be found in Appendix 1.

1.4 Theological framework

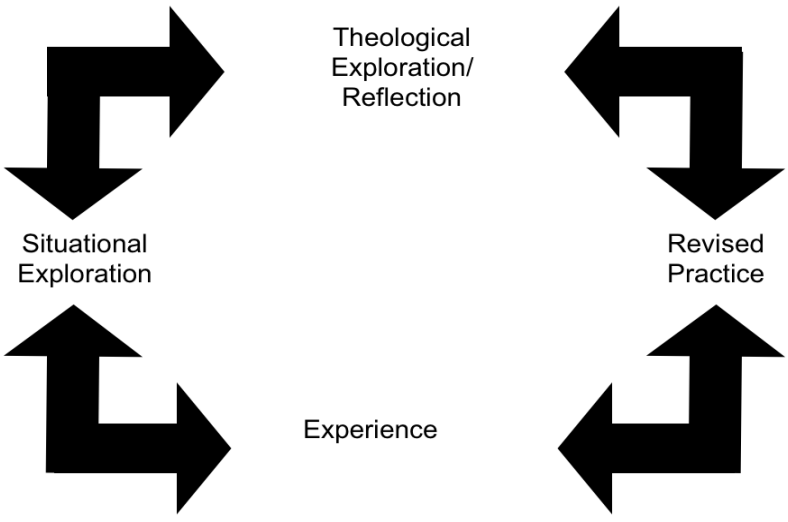
As noted above, Pattison's (1989) Mutual Critical Conversation and Osmer's (2008) Four Tasks of Practical Theology, (also referred to as the Pastoral Cycle), will frame the multidirectional flow of dialectical dialogue in my TR. Nonetheless, the plurality of models for relating theory and practice have been influential in shaping the process of TR, including Lartey's (1996) contributions to theological form, Browning's (1991) insights on critical moral reasoning and Green's (1990) recognition of the need for the imagination as new traditions emerge.

1.4.1 Stephen Pattison (1989): Mutual Critical Conversation

Pattison bases his model on the metaphor of a conversation between friends who have differences but are open to learning from one another. Pattison's method (Woodward, Pattison and Patton, 2000) entails a dialectical mutuality between these participants which involves listening and does not preclude, rather often requires, challenging each other's perspectives. Pattison is aware of the complexity of TR and the variety of Christian perspectives that can apply to any potential circumstance. To facilitate a methodological approach, he (2000, p.141) states that relevant questions within the conversation can "act as

critical starting points against which to assess and compare the relative positions and perceptions of participants in a particular conversation." Pattison suggests that his model is a relatively coherent method of understanding and synthesising the complex relationships between situations, theology and theories. The three-way critical conversation which he (2000, p.139) proposes, entails a dialectic relationship between the researcher's "own ideas, beliefs, feelings, perceptions and assumptions, the beliefs, assumptions and perceptions provided by the Christian tradition and the contemporary situation which is being examined." Pattison (2000) proposes personifying these three entities, then further envisaging them reflectively, enquiring with each other to bring a greater depth of understanding to the situation being explored. One of the foremost merits of Pattison's approach is that he simplifies TR by ensuring that it is accessible to all who would like to consider how faith relates to experience. It is vital for Pattison (2000, p.141) and helpful in considering methods that the TR should be "critical" since it is in the re-examination of formerly held beliefs that theology itself becomes a dynamic activity.

Figure 1: A model of TR: Pattison's 'Mutual Critical Conversation' (Swinton and Mowat, 2016, p.77)



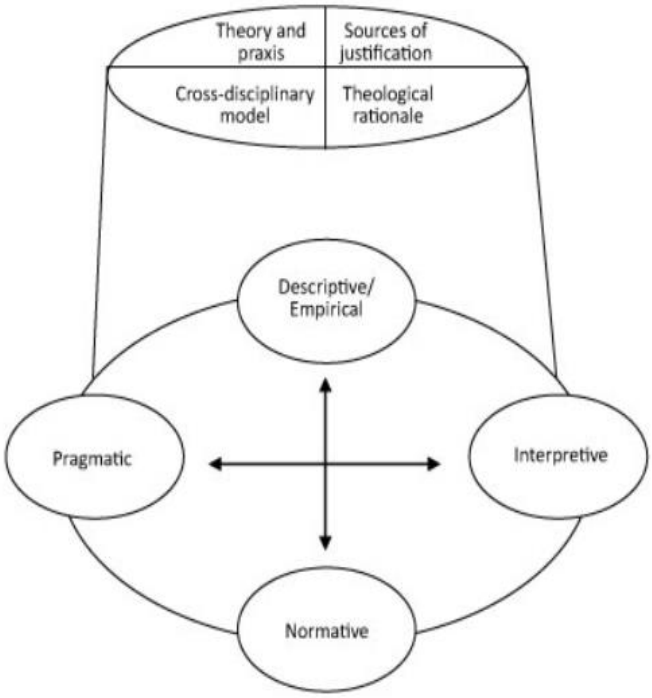
Pattison (2000) does accept that his method has limitations, in that the traditional perception that theology constructs ultimate doctrines and truths is challenged. Furthermore, individual theologies are, by necessity, subjective and therefore the relationship between the contemporary individual and the Tradition is debatable. In an attempt to address the subjectivity, Northcott (in Willows and Swinton, 2001, p.63) comments: "I wonder if there is not a need for a fourth category of insights from secular disciplines including psychological,

sociology and organization theory." The application of this suggestion is appropriate for this thesis, given that there is a crucial need for formal inclusion of other disciplines as conversational partners.

1.4.2 Richard Osmer (2008): Four Tasks of Practical Theology

Osmer (2008, p.32) states that practical theology is an invitation to interpret the texts of contemporary lives and practices of "living human documents." Osmer's basic framework reflects Browning's (1991) model as he begins with experience of a social context. However, Osmer explicitly repudiates the tendency to see practical theology as the dominion of the social sciences, through adopting a rigorous theological methodology. Osmer's (2008, p.241) work insightfully draws on the concept of a "reflective equilibrium." While drawing from van Huyssteen (1999), Osmer explains how his reflective equilibrium concludes that practical theology is, like other contemporary research areas, extremely pluralistic. It seeks to identify tasks or elements which are ubiquitously held, even if they are viewed differently by other practical theologians. Osmer (2008, pp.xv-xvi) identifies the four tasks of practical theology which represent a "reflective equilibrium" in the field, as the "descriptive-empirical, interpretive, normative and the pragmatic task." Osmer (2005, p.306) clarifies that these tasks are interdependent; however, they are not fixed to flow sequentially, because the way in which concepts are formed and tasks are performed varies, depending upon "meta-theoretical" decisions. He (2005, p.306) identifies at least four meta-theoretical subjects which must be considered either implicitly or explicitly: "theological rationale, the theory-praxis relationship, sources of justification and models of cross-disciplinary work." Osmer (2008) does, however, recognise that practical theologians bring a multiplicity of different methods and presuppositions to these tasks, which leads to the emergence of a wide variety of outcomes.

Figure 2: Osmer's (2008) Four Tasks of Practical Theology



On the whole, Osmer (2008) offers a coherent approach to the reality of interdisciplinary issues which occur within church communities in a simplified form, further discussion on interdisciplinary dialogue is in Appendix 2. As Osmer (2008) provides a structured approach to pastoral care as one aspect of practical theology, his pastoral cycle will function as an underpinning principle which will guide the methodology for the TR and will be further developed in the pastoral care section on pp.60-76.

1.5 The cycle of TR: Contextualising the conversational partners

The cycle of TR will commence by the first voice outlining the condition of experiencing an ED with reference to a NI context. The second voice will outline the characteristics of fundamentalism with reference to a NI context. The third voice will illustrate the current understanding of pastoral care and the fourth voice will provide a challenge to contemporary thinking in NI with relevant areas of feminist theology. The fifth voice is the findings from the interviews with those who have experienced EDs, their carers and those claiming insight into both church communities and mental health. This latter voice derived from the qualitative data will be critically analysed in Chapter Five as the literature and qualitative research are

synthesised and ordered in four sections: EDs, fundamentalism, pastoral care and feminist theology. The pastoral care and feminist literature in particular will provide a bridge to the response in Chapter Six. Finally, in Chapter Six the findings and existing literature are analysed alongside my own insight and structured as recommendations for church communities and the NHS. Voices One, Two, Three and Four which will provide a contextual understanding of the research fields, prior to the presentation of the findings defined in Voice Five. Furthermore, hearing Voices One to Five will provide an understanding for the reader and provide a rationale for my recommendations as specified in Voice Six. The theological methodology for accurately hearing Voice Five will be discussed in the following section on theological methodology.

Voice One: Relevant literature on EDs with particular reference to NI context.
Voice Two: Relevant literature on fundamentalism with particular reference to NI context.
Voice Three: Relevant literature on pastoral care.
Voice Four: Relevant literature on feminist theology
Voice Five: Qualitative data from interviews with those who have experienced EDs, carers and those claiming insight into church communities and mental health.
Voice Six: My own insight in light of the literature reviews, findings and synthesis.

1.6 Theological methodology

In an effort to effectively hear and provide theologically-valid recommendations for those experiencing EDs, their carers and church communities, the method of TR, hermeneutics and the use of the Bible have been significant theological factors. The method of TR is discussed below, hermeneutical considerations are discussed in Appendix 3 and issues relevant to the Bible and practical theology are discussed in Appendix 4. The social research methodology which has been used for data collection and analysis will be expanded on in Chapter Three.

TR is not a singular process but has a diversity of expression. Graham, Walton and Ward (2005) provide a typology of TR focusing on different contexts and methods. Three of their approaches contribute significantly to and raise different critical questions to add to the conversation. First, "Theology by Heart" (Graham, Walton and Ward, 2005, pp.18-45) focuses on Boisen's (1936) "Living Human Document." Boisen demonstrates that he had a two-fold

objective for his case-study method: "I have sought to begin not with the ready-made formulations contained in books but with the living human documents and with actual social conditions in all their complexity." (1936, p.185). Therefore, the analysis of individual human experience remains important in this thesis, but so do the experiences of a social situation, including church communities, and in particular, fundamentalist communities. In their chapter on "Speaking in Parables," Graham, Walton and Ward (2005, pp.47-77) promote an interpretative framework of constructive narrative theology. They (2005, p.47) propose that formative revelations from God can be uncovered through understanding that people have the creative capacity "to construct meaningful stories out of the varied circumstances of their lives." Finally, "Speaking of God in Public: Correlation" (Graham, Walton and Ward, 2005, pp.138-169) is also important to the reflective process of this thesis. Graham, Walton and Ward (2005, p.138) explain:

> The correlative method is one that emphasises the importance of theology's engagement with contemporary culture, be that philosophical, aesthetic, political or scientific. This approach to TR regards the evolution of Christian thought and practice as necessarily taking place in public: the Christian tradition should be prepared to engage in an open exchange of ideas and debate with different cultural disciplines, values, images and world-views.

This model of TR has two dimensions or strands: the apologetic and the dialectical (Graham, Walton and Ward, 2005). An apologetic dimension is primarily Tillichian (1963) and engages with aspects of contemporary culture to demonstrate that Christian faith provides answers to the pressing questions of the day. Tracy's (1975) dialectical dimension, however, from which this thesis is more inclined to draw, recognises that expressions of contemporary culture may contribute to theological analysis and understanding in their own right. Consequently, the dialectical approach accepts that in the dialectical exchange between theology and culture, theology both contributes and receives (Graham, Walton and Ward, 2005). This method has been used effectively in Pattison's Critical Conversation. TR must be thoroughly conversant with both the Christian tradition and the sociocultural discourse outside the church, otherwise it will not make any meaningful impact on the public sphere. Thus, through careful contextual research this thesis intends to offer wise and helpful suggestions to reform practice which will impact on the quality of care in the public sphere.

1.7 Aims:

This research is timely, as the NHS in NI is currently exploring how to transform the way in which care is delivered, and provide more collaborative networks for service providers, service users and carers (HSCNI, 2015). Wilson et al. (2015, p.4) acknowledge that improvements have been made in service provision since the Bamford Review and Transforming Your Care (Department of Health and Social Services and Public Safety for Northern Ireland (DHSSPSNI), 2007); however, they also note that "funding cutbacks have curtailed progress and will continue to do so in the coming years." Collaboration with the church community offering effective pastoral care could be a financially prudent choice for the NHS. Furthermore, when considering long waiting lists for treatment, church-based care close to the home of the individual experiencing the ED, could potentially increase treatment compliance, enhance the potential for recovery and prevent relapse in those experiencing EDs.

Therefore, the overarching aim of this thesis is:

To critically analyse the condition of having an ED and the context of fundamentalist environments, and to use the challenge of feminist theology to provide a response to improve the pastoral care of women experiencing EDs in church communities.

The subsidiary aims of this thesis are:

1. To critically analyse the narratives of those who have experienced EDs in terms of the genesis and progression of, and recovery from the disorder.

2. To critically analyse the narratives of women who have had or currently have EDs, in relation to their self-perception, perception of God, and of relationships.

3. To critically analyse the narratives of those who have experienced EDs and carers in terms of their illness and previous encounters with churches, Christians and pastoral care.

4. To critically analyse the language used by carers and insightful voices from church communities when describing the relationships between EDs, God and church.

5. To critically analyse the narratives of those claiming insight into church communities and mental health regarding caring for those experiencing EDs in NI.

6. To assess and respond to the effectiveness of current service provision for those who have experienced EDs, with regard to what has worked in rehabilitation and what has hindered rehabilitation, and to respond to the perceived degree of integration between church communities and the NHS in NI.

7. To critically analyse whether insights from feminist theology have potential to provide church communities with more effective care solutions for those experiencing EDs and their carers.

8. To critically analyse whether, realistically, church communities could contribute to more effective care for those experiencing EDs and their carers.

1.8 Conclusion

As empirical realities interact with the presuppositions and the Christian tradition in pastoral care, it is evident that TR cannot be a linear exercise. However, there is an urgent necessity to understand the worldview both of women who have experienced EDs and their carers, particularly concerning their experience of having an ED in relation to their experience of church communities in NI. Furthermore, those claiming insight into church communities and mental health will help to develop pastoral care for those experiencing EDs in NI. Thereby, church communities will benefit from findings which identify the helpful ways in which they aid, and unhelpful ways in which they hinder rehabilitation. A practical theological approach will form the lens through which to explore the potential for rehabilitative support in the form of Christian pastoral care in church communities. By contributing uniquely to the body of knowledge concerning care of women experiencing EDs and their carers, I will be in a position to offer insightful recommendations to church communities and healthcare providers. Chapter Two will now present the first four voices in the conversation on aspects of the church that could help, and aspects that could hinder, rehabilitation for those experiencing EDs.

2. Chapter Two: Listening to the voices in the conversation

The critical conversation will be developed in this chapter as four of the voices noted in Chapter One are heard. The purpose of each voice is to provide relevant understanding in order to provide the basis for a critical analysis in Chapter Five and Six, as the voices interact:

Voice One: Understanding the condition of an ED from existing literature.
Voice Two: Understanding the context of the culture of fundamentalism from existing literature.
Voice Three: Understanding the context of care of pastoral care from existing literature.
Voice Four: Understanding relevant insights of feminist theologians and contributors to the discussion from existing literature.

2.1.1 Voice One: ED literature review

Introduction

EDs are significantly different from normal bodily dissatisfaction (Joseph et al., 2016) or general dieting which is part of everyday life for many women (Neumark-Sztainer et al., 2011). However, longitudinal research does indicate that bodily dissatisfaction, inadequate support and the internalisation of a 'thin ideal' are predictors of EDs (Stice et al., 2017). Nevertheless, understanding the shift from a normative measure of interest in dieting to a pathological concern remains incomplete (Striegel-Moore and Bulik, 2007). When EDs take root, the "rigid inaccessibility" that develops, makes the sufferers notoriously difficult to reach (Willner, 2009, p.16). Consequently, there is an urgency to help the increasing number of individuals who are engaging in these life-threatening behaviours, as, despite having received specialist treatment, the number of women who relapse is alarmingly high (NICE, 2017). Although there is contention amongst specialists surrounding the core issues of EDs, there is unanimity that EDs are serious illnesses. The literature review will be guided by five key areas:

2.1.2 Categorisation of EDs: Anorexia Nervosa (AN), Bulimia Nervosa (BN), similarities and subtypes of AN and BN, remission and the aetiology of EDs.

2.1.3 The aetiology of EDs: The biologically-based mental illness (BBMI) approach and the sociocultural approach.

2.1.3.1 Personality and temperament factors: Four key areas: clinical perfectionism, core low self-esteem, mood intolerance and interpersonal difficulties.

2.1.3.2 Environmental stressors and effects: Trauma and attachment difficulties.

2.1.3.3 Sociocultural factors and effects: Sociocultural risk factors, gender and objectification, susceptibility to shame and identity.

2.1.4 Treatment of EDs and spirituality-based approaches: Defining spirituality, spirituality-based approaches, spirituality and attachment to God, and alternative forms of spirituality and religion.

2.1.5 ED treatment in NI: Integrated care, community-based care, holistic care and spirituality and mental health in NI.

2.1.2 Categorisation of EDs

A notoriously controversial area of psychiatry is the accurate diagnosis of EDs; historically this has been marked by persistent change and conflict. The Diagnostic and Statistical Manual of Mental Disorders 5th ed. (DSM-5) section on EDs (American Psychiatric Association (APA, 2013, p.329) begins with the statement: "Feeding and Eating Disorders are characterized by a persistent disturbance of eating or eating-related behavior that results in the altered consumption or absorption of food and that significantly impairs physical health or psychosocial functioning." The DSM-5 clarifies that when eating causes distress and is debilitating in some manner, this signifies the main symptoms of an ED. Formerly, owing to the all-encompassing nature of the criteria used for 'Eating Disorders – Not Otherwise Specified' (ED-NOS) in the DSM-IV (APA, 1994) and the DSM-IV-TR (APA, 2000), 40-60% of the clinically diagnosed ED cases were ED-NOS. This umbrella category included symptoms which were common to the majority of those experiencing EDs and therefore it was not particularly

useful in guiding a treatment strategy (Machado, Gonçalves and Hoek, 2013). In an effort to clarify the ED-NOS group, the DSM-5 changed the categorisation scheme to facilitate diagnosis and treatment planning. The DSM-5 recognises three main ED diagnoses: AN, BN and binge eating disorder (BED). For the purpose of this thesis I focus mainly on BN, AN and subtypes of both disorders, as they are deemed to have the most overlap in aetiology and symptomology (APA, 2013). Further literature on similarities and subtypes of AN and BN and more in-depth literature on relapse and remission can be found in Appendix 5.

Anorexia Nervosa (AN)

AN is a complex syndrome characterised by medical morbidity made manifest by specific behavioural, cognitive and physical criteria (APA, 2013). As recorded in the DSM-5, because of the severe weight loss incurred in AN, diagnosis is not time-delineated. AN is now defined by certain criteria including a resolute engagement in behaviours that prevent weight gain, a fear of fatness, low body weight and a disturbance in the sense of body image (APA, 2013). The aetiology of AN is widely recognised to include a confluence of social, psychological and biological factors (Le Grange, 2016). It is therefore not surprising that its aetiology has significant psychiatric comorbidity in the DSM-5 (APA, 2013).

Bulimia Nervosa (BN)

Before BN's inclusion in the DSM-IIV (APA, 1980), it had posed a diagnostic difficulty since its original definition by Russell in 1979 (Smink et al., 2016). There are two main reasons why this is the case: first, when considering the pervasiveness of shame in BN, most sufferers are initially secretive about their behaviour (Tillman, 2009); second, making a diagnosis is more difficult because significant weight loss does not commonly occur in BN (Bodell and Keel, 2015). There have been limited changes to the DSM-5 (APA, 2013) criteria for BN. As Crow (in Smolak and Levine, 2015, p.106) explains that "[t]he criteria were liberalized to allow for binge eating and purging that occurs once per week rather than twice per week during the 3-month period." This amendment from the DSM-IV was designed to encapsulate those who came close to the criteria for BN but were not bingeing and purging frequently enough to warrant a diagnosis. This change is intended to help with a treatment direction for those formerly diagnosed with ED-NOS and increase the diagnosis of BN accordingly (Machado, Gonçalves and Hoek, 2013). Due to the multifaceted nature of BN, the stigma, shame and

subsequent hesitancy in seeking help, present obvious and continued difficulties in BN diagnosis.

2.1.3 The aetiology of EDs

Although a multidimensional approach to the aetiology of EDs is commonly preferred, the two dominant and general paradigms are the BBMI approach and the sociocultural approach (Smolak and Levine, 2015). The BBMI approach suggests that there is a genetic predisposition in the individual who develops an ED, in contrast to the sociocultural approach which emphasises that conditioning and cultural factors are the primary influencers. Both BBMI and sociocultural approaches acknowledge that environmental stressors such as trauma, especially sexual abuse, may increase the potential for developing an ED (Gilbert and Miles, 2014). In the following sections I will use relevant literature to explain: personality and temperament factors, environmental stressors and sociocultural factors.

2.1.3.1 Personality or temperament characteristics

Four key areas

After a significant volume of research on modified CBT approaches to EDs, Cooper and Fairburn (2011) found that they were repeatedly having poor treatment results despite their determined views that EDs are primarily cognitive in nature. Therefore, based on their clinical experience, they decided to include four additional factors which contribute to the initiation, perpetuation and maintenance of AN and BN (Cooper and Fairburn, 2011). Fairburn, Cooper and Shafran (2003, p.509) now recognise the maintaining factors in four key areas: "clinical perfectionism, core low self-esteem, mood intolerance and interpersonal difficulties." These processes form the bedrock of their transdiagnostic theory of EDs (Fairburn, Cooper and Shafran, 2003).

Clinical perfectionism

Perfectionism is conceptualised as serious attempts to rigorously control shape, weight and eating (Treasure and Schmidt, 2013). The core psychopathology is obsessional attention to performance, a fear of failure, and self-criticism which derives from heavily critical evaluations of performance (Stoeber et al. 2016). Inability to accomplish unachievable

standards motivates rigorous control; this then functions to perpetuate the ED symptoms (Pinto-Gouveia, Ferreira and Duarte, 2014). Historically, perfectionism is a trait which is predominantly characteristic of those who experience AN. Cano et al. (2016), however, confirm that high levels of perfectionism are present across the spectrum of ED psychopathology. Shafran, Cooper and Fairburn (2002, p.778) refer to "clinical perfectionism" as "the over-dependence of self-evaluation on the determined pursuit of personally demanding, self-imposed, standards in at least one highly salient domain, despite adverse consequences." With "clinical perfectionism," the sense of self-worth and self-esteem of the woman experiencing the ED are derived almost exclusively from achieving these standards. After social comparisons, there is commonly a cycle of harsh self-evaluation which consequently breeds feelings of devaluation, ostracism and inferiority. The low self-esteem developing through the establishment of impossible standards causes a deep shame which exacerbates the disorder (Pinto-Gouveia, Ferreira and Duarte, 2014). Those who experience EDs will never attain their ideal self and thus will always equate their perception of the real self with being a failure (Treasure and Schmidt, 2013). Furthermore, this dichotomous thinking inevitably leads to feelings of never being good enough (Noordenbos, Aliakbari and Campbell, 2014). In their neuropsychological study, Roberts, Tchanturia and Treasure (2010) document the rigidity associated with perfectionism in those experiencing EDs. They (2010, p.969) suggest "targeting poor flexibility as a cognitive maintaining factor … [and an] investigation of the biological correlates of poor set-shifting." Consequently, those with an ED are less able to adapt to unfavourable circumstances, traumatic events and stressful situations. There is a certain intolerance of uncertainty (Renjan, et al., 2016) and as a consequence, a tendency to react negatively on an emotional, cognitive, and behavioural level to uncertain situations and events (Frank et al, 2012). Perfectionism has been linked to psychosocial and developmental factors such as an insecure attachment style (Cano et al., 2016). It appears that perfectionistic standards in various areas of life tend to be maintained even following recovery from an ED (Egan, Wade and Shafran, 2011).

Core low self-esteem

The concept of self-esteem is associated with core self-evaluative feelings (Baumeister, 2013) and explained as an attitude to, and appraisal of, the self (Rosenberg et al., 1995). Research findings support the crucial factor of low self-esteem as a prerequisite and an accelerating

factor in EDs (Kelly, Vimalakanthan and Carter, 2014; Fairburn et al., 1999; Caglar-Nazali et al., 2014). Rohde, Stice and Marti (2015) suggest that for adolescent girls in particular, body dissatisfaction is integrally linked with the concept of self-esteem and is one of the most consistent predictors of early ED onset. Such core low self-esteem often subverts compliance with treatment, and also contributes to their perfectionistic traits in an effort to attain a sense of self-value. Research suggests that low self-esteem is a key predictor of early treatment dropout (Fassino et al., 2009) and poor treatment outcome (Kelly, Vimalakanthan and Carter, 2014).

In recovery, those who experienced EDs have recalled experiencing feelings associated with grief and loss, as they no longer have the ED to manage, affect, and regulate their emotions (Collin et al., 2016). It is therefore not surprising that as BMI increases, self-esteem decreases when it is understood that the self-esteem of those experiencing ED is commonly correlated with weight loss (Brechan and Kvalem, 2015). This incongruity demonstrates the complex dynamic between EDs and self-esteem and is supported by findings which confirm that those experiencing AN feel a sense of pride and being powerful, superior and special in correlation to losing weight (Brockmeyer et al., 2013). A more effective strategy for promoting self-esteem is necessary (Cornelius and Blanton, 2016). Collin et al. (2016) agree and suggest that treatment interventions for self-esteem must be addressed in a multidimensional construct, as many previous interventions for self-esteem were in ED-specific inpatient units.

Mood intolerance

Research suggests that disturbances characterised by high negative affect and emotionality including depressive symptoms, are common to AN and BN psychopathology (Bulik, 2002; Racine and Wildes, 2015) and are also risk factors which predict the onset of an ED (Stice et al., 2017). Co-occurring mood disorders and anxiety have been diagnosed as comorbid in a significantly high number of women experiencing BN and AN (Stice et al., 2017; NICE, 2017). The pervasiveness and intensity of the critical inner voice correlate to mood intolerance as a maintenance factor in AN in particular (Pugh and Waller, 2016). In a quantitative study, 94.5% of those who experienced EDs detailed their experience of a critical inner voice, and 21.4% of the group heard the critical inner voice continuously (Noordenbos, Aliakbari and Campbell, 2014). Clients with EDs have reportedly called this voice an ‘inner dictator’ (Bruch, 1978), an

'inner negativist' (Claude-Pierre, 1997) and an 'enemy' (Tierney and Fox, 2010). The intensity of the inner struggle and conflict is documented by some damaging psychosocial trends, including difficulty regulating emotions and a higher occurrence of anxiety and despondency (Whiteside et al., 2007). Pugh and Waller (2016) suggest that specialists working with those experiencing AN should frequently enquire about voices and, if they are present, what they are saying. Pre-existing treatment methods working with voices could be explored as an aid to treatment intervention as there is a significant overlap with other diagnoses such as psychosis (Pugh and Waller, 2016).

Fear is particularly prevalent in those experiencing EDs. Existing research confirms that those who have experienced EDs have a heightened reactivity to threat (Gorka et al., 2017) and a high punishment sensitivity (Harrison et al., 2010; Eneva et al., 2017) which increases anxiety levels. Furthermore, elevated levels of anxiety and sensitivity are symbiotically related to fears of losing control (Treasure, Smith and Crane, 2016). Bailey and Waller (2017) argue that those experiencing EDs have a predisposition to extreme fear conditioning. Although fear is most obviously exemplified in the fear of weight gain, those experiencing EDs are prone to perceive hostility in the faces of others (McFillin et al., 2012), and often misinterpret neutral facial expressions as angry (Ridout et al., 2012), this has a direct impact on withdrawal and social isolation. AN is commonly considered to be more prone to emotional suppression and behavioural inhibition, thus clients more frequently manifest shyness (Cassin and von Ranson, 2005). In contrast, those experiencing BN tend to present with more traits of emotional instability and impulsivity, and commonly co-present with non-suicidal self-injury and substance abuse (Gonclaves et al., 2016; Steiger and Thaler, 2016). However, those experiencing both AN and BN usually present with both emotional instability and emotional suppression at different stages of their disorder (APA, 2013).

Interpersonal difficulties

When assessing remission, Dingemans et al. (2016) found that those exhibiting high levels of interpersonal distrust were less likely to have experienced a significant change in ED psychopathology. The issue of distrust is a double-edged area of concern for those experiencing EDs: distrust of oneself and distrust of others. Integral to feelings of distrust are compounded fears of rejection and of negative social evaluations which often initiate

strategies of disconnection (Cardi et al., 2017). Concerns are centred around negative social evaluations combined with an inhibited flexibility when responding to unforeseen conditions (Arlt et al., 2016). As a result, shame and feelings of unworthiness often cause women experiencing EDs to retreat from interpersonal connections and is often a barrier which prevents help-seeking (Ali et al., 2017). Strategies of disconnection frequently arise around shame, self-criticism and a sense of unworthiness which is linked to psychological inflexibility (Duarte, Ferreira and Pinto-Gouveia, 2017). Those who experience EDs often disconnect from relationships, sensing that their behaviours may, at least temporarily, alleviate emotional pain, increase feelings of safety and decrease vulnerability in relationships. The majority of those who have experienced EDs highlight that social interactions are highly problematic for them, and by consequence often seek reassurance to cope when faced with interpersonal interaction (Mason et al., 2016). This pattern often occurs cyclically: when feelings of shame and vulnerability decrease, interpersonal connection increases (Duarte, Ferreira and Pinto-Gouveia, 2016).

There is growing evidence to suggest that those who experience EDs have an impaired capacity to express emotions, misperceive social cues and have consequential social difficulties (Ambwani et al., 2016; Westwood et al., 2017; Lang et al., 2016). These studies are supported by historical descriptions (Bruch, 1978) and established recent models (Fairburn, Cooper and Shafran, 2003; Treasure and Schmidt, 2013) that place socio-emotional difficulties as fundamental to ED. Bruch (1978) developed the hypothesis that AN is a condition that grows out of the inability to experience or express emotion. Difficulties with emotional experience and how this is managed through expression have crucial implications for how women experiencing EDs are perceived and received by others (Moskovich et al., 2017). Wilfley et al. (in Treasure, Schmidt and van Furth, 2005) indicate that the onset and maintenance of ED symptomatology in some individuals may be directly linked to the lack of skills to establish and sustain supportive relationships, or to cope with problematic social situations. Similarly, Amianto et al. (2013) correlate dysfunctional attachment behaviour with insecurity and a sense of vulnerability in interpersonal relationships. Eisler et al. (in Treasure, Schmidt and van Furth, 2005) suggest that increasingly positive treatment results have a correlation with security in interpersonal relationships. Furthermore, interpersonal processes and environments can contribute to concerns about controlling shape, weight and

eating. Research confirms that when interpersonal functioning is disturbed, this usually has a negative impact on treatment response (Cooper et al., 2016; Agras, Fitzsimmons-Craft and Wilfley, 2017). When considering long-term treatment, interpersonal psychotherapy (IPT), an attachment-based and problem-focused treatment for depression and relationship problems, is now deemed to be similar in effectiveness to CBT for ED clients (Cooper et al., 2016). There is preliminary data to suggest that through using client preferences, values and perspectives for optimising treatments can be extremely beneficial not only for service providers but also service users to increase interpersonal connection and self-esteem (Peterson et al., 2016).

2.1.3.2 The environmental stressors and effects

Trauma

Despite BBMI prototypes, many women experiencing EDs exhibit negligible psychopathology. Steiger and Thaler (2016) explain that precise psychopathological traits are not necessary prerequisites for the existence of EDs. Brewerton (2017) suggest that those who develop EDs can often experience pre-existing anxiety disorders, which can include PTSD. Taking into consideration traumatic experiences is a vital contextual factor that shapes the course of EDs and culminates in an increased sensitivity to adversity and stress (Brewerton, 2017). Furthermore, there is a distinct correlation between childhood and adolescent sexual abuse and EDs (Goncalves et al., 2016; Hodge and Bryant, 2017).

The National Women's Study (n = 4,004) is the largest study analysing the psychiatric comorbidity of the relationship of trauma history to BN and BED (Dansky et al., 1997). Using this database, Dansky et al. (1997) obtained thorough recollections of women's crime victimisation experiences. They report that

> 13.6% of the respondents reported a rape had occurred at some point during their lives. The lifetime prevalence rates for sexual molestation, nonsexual contact/attempted sexual assault, and aggravated assault were as follows: 12.3%, 9.5%, and 8.9%, respectively. Additionally, when all categories of direct assault were collapsed into one, 31.7% of the respondents reported some type of direct victimization. (1997, p.219)

These findings provide a strong rationale for the theory that trauma, particularly during formative years, can be an aetiological risk factor for EDs, particularly for BN (Goncalves et al., 2016; Hodge and Bryant, 2017). Moreover, there is evidence to suggest that many of those who experience EDs have experienced multiple, compounded and recurrent traumatic episodes (Brewerton, 2017).

A sense of disconnection and detachment between body and mind often culminates in feelings of disembodiment and dualism for those who experience EDs (Dakanalis et al., 2016; Gaete and Fuchs, 2016). Van der Kolk (2014) suggests that such disruptions indicate that the central and peripheral nervous systems failed to process the experience collectively at the time of the trauma. Consequently, the feeling of estrangement from the self, in the sense of weak self-relatedness, causes individuals to perceive their bodily self somewhat more like a stranger (Adler et al., 2016). It is important to note that traumatic events in themselves do not predict EDs as an outcome, but if the trauma is not psychologically integrated, the likeliness of developing an ED or related mental health issue increases (Brewerton, 2017). When this happens, Shors and Millon (2016) suggest that the memory of a traumatic event becomes detached, distorted or repressed through dissociation at the time of trauma and therefore becomes resistant to retrieval. When considering the pervasiveness of incidences of dissociation in those experiencing EDs, Vanderlinden et al., (2016) explain that a sample of those diagnosed with EDs presented with the same symptoms as a group of patients diagnosed with dissociative disorders. Dissociative experiences debilitate emotional connection which adds to feelings of disembodiment and an emotional numbness (Petrucelli, 2016). Understanding the processes that give rise to the estranged sense of self in depersonalisation is vitally important in therapeutic contexts (Adler et al., 2016).

Trauma: Psychological influences

Herman (1992) contends that recovery from any traumatic experience requires restoration of control and power for the traumatised person and must involve addressing interpersonal difficulties. She explains (1992, p.33) that "[p]sychological trauma is an affiliation of the powerless. At the moment of trauma, the victim is rendered helpless by overwhelming force." When a person is confronted with extreme helplessness, the body interprets this as a catastrophe and responds accordingly. Beste (2007, p.5) explains that trauma "is the

experience of terror, loss of control, and utter helplessness during a stressful event that threatens one's physical and/or psychological integrity." The sense of being overwhelmed is the experience that almost all victims of trauma report, including severe emotional distress, sometimes in the appearance of frequent flashbacks and nightmares as memories intrude into their present experience. Herman (1992, p.37) writes: "[t]he traumatic moment becomes encoded in an abnormal form of memory, which breaks spontaneously into consciousness." Indeed, any stimulus has potential to prompt a flashback because of the manner in which the brain organises information in a massive web of interwoven associations. Van der Kolk (2014) explains that the force and extremity of trauma result in a crisis of reintegration in which the human person is unable to reset himself or herself. In normal processes of memory, a clip or piece of the past is accessed in the present, stirring corresponding emotions. In traumatic memory, if the pain is overwhelming, there may be a total disconnect between experience and present emotion causing a freeze response; this is often associated with extreme terror.

Trauma: Somatic responses

Van der Kolk (2014) and Levine (2010) emphasise that the essential root of trauma resides in somatic memory. Van der Kolk (in Wylie, 2004, p.39) emphasises that "[t]he imprint of trauma doesn't sit in the verbal, understanding part of the brain, but in much deeper regions – amygdala, hippocampus, hypothalamus, brain stem – which are only marginally affected by thinking and cognition." Consequently, Levine (1997) and van der Kolk (2014) both claim that the initial step in trauma healing is to restore a person's capacity to regulate their bodily affect in relationship to the external environment. Van der Kolk (2002, p.48) explains that "to overcome a traumatic experience, one must have a physical experience that directly contradicts the helplessness and sense of inevitable defeat associated with the trauma." The empowerment and restoration of internal safety inside one's own body helps to manifest sensations to counterbalance the sense of being out of control. As Levine (2005) clarifies, traumatic response is as contingent on the individual's understanding of the experience as the experience itself, and therefore what may seem less important for one individual may be tragic and devastating for another. Devastatingly though, for some individuals, the lingering effects and fear-based responses of trauma manifest themselves through unconscious

somatic responses even decades after the event. Fear-based reactions disproportionate to the trigger increase a sense of vulnerability, shame and anxiety in the person who appears to be overreacting, therefore traumatised individuals often try to numb their emotional pain. Whitehead (2010) argues that such fear responses as an evolved and adaptive response to threats would be better viewed from the perspective of the hope of survival. Similarly, van der Kolk (2014, p.245) argues that "[t]his sets the stage for trauma resolution: pendulating between states of exploration and safety, between language and body, between remembering the past and feeling alive in the present." Safe exploration forms the basis for maturing and integration for the one who has experienced trauma.

Trauma: Safety in recovery

When an individual has experienced trauma, they cannot find an internal safe space in which to rest and recover, which often results in feelings of high emotional alert and an exhausting over-sensitivity. By consequence, this often results in isolation and an inability to cope with the unpredictability of interpersonal relationships. Herman (1992) suggests that establishing safety is the first priority of treatment and no treatment can progress without this. She outlines that psychological trauma causes disconnection and disempowerment and is adamant that a connection must occur for therapeutic work to be effective. Herman (1992) believes that because the feelings of helplessness from trauma are related to the primary violation of trust in interpersonal relationships, it is only through the restoration of relationships that healing is possible. She writes (1997, p.160): "[s]urvivors feel unsafe in their bodies. Their emotions and their thinking feel out of control. Often, they also feel unsafe in relation to other people." Trauma specialists are consistent in their belief that the possibility of healing and transformation is possible through the creation of an authentically safe therapeutic environment which inspires survivors to gently and slowly reconnect with everyday life.

Rothschild (2004) emphasises that containment and safety are the most crucial elements in trauma work and has coined the term 'applying the brakes.' She identifies several fundamental principles that can help make the process of trauma recovery safe and effective, and explains (2004, p.1):

> I never help clients call forth traumatic memories unless I and my clients are confident that the flow of their anxiety, emotion, memories, and body sensations can be contained at will. I never teach a client to hit the accelerator, in other words, before I know that he can find the brake.

Similarly, Kluft's (1993, p.42) maxim "the slower you go, the faster you get there" affirms that trauma recovery cannot be rushed and extreme caution must be taken so that individuals do not feel too vulnerable too soon because this can be detrimental in the formation of a therapeutic relationship.

Attachment

After reviewing a significant number of clinical and non-clinical studies, Mikulincer and Shaver (2012, p.11) describe the concept of attachment as "a very fruitful framework for studying emotion regulations and mental health." The founder of attachment theory, Bowlby (1973), suggests that in moments of distress, a caregiver's response or lack of response to soothe a child is internalised by the child. In childhood, this attachment becomes a cognitive construct of how to deal with distress and forms the foundation for affect regulation in adulthood. When distressed, those who have a secure attachment style can be comforted by themselves or others, whereas those who have an insecure attachment style find this intensely painful (Kuipers et al., 2016). Instead, they have a propensity to control emotions rigorously, withdraw from others, become overwhelmed by emotions, or become overly attached to others (Kuipers et al., 2016). To determine the features of attachment styles, Ainsworth et al. (1978, p.437) propose two types of insecure attachment: "anxious–ambivalent and anxious–avoidant." Main and Solomon (In Yogman and Brazelton, 1986) added a third insecure style, labelled as "disorganised." An association between attachment insecurity and EDs has been a consistent finding of numerous studies since the 1980s (Armstrong and Roth, 1989). More recently it has attracted increasing theoretical and empirical research interest (Tasca and Balfour, 2014; Caglar-Nazali et al., 2014) particularly in the realm of body dissatisfaction and attachment insecurity (Grenon et al., 2016). Attachment insecurity has been found to be much more common in women experiencing AN and BN than in healthy controls (Grenon et al., 2016; Ward, Ramsay and Treasure, 2000).

A low ability to self-soothe has been correlated with higher severity of ED symptoms and higher attachment anxiety, which is linked to the sensitivity to rejection in those experiencing EDs (De Paoli et al., 2017). Tasca, Ritchie and Balfour (2011) found that individuals who exhibit an anxious attachment style were more often linked with BN, and individuals who show avoidant attachment behaviour are more often related to those experiencing AN (Tasca, Ritchie and Balfour, 2011). The acts of increased food intake, subsequent purging and excessive exercise are often used to preoccupy oneself from unbearable emotional distress. For those experiencing AN in particular, the act of circumventing food may relieve negative emotions as it gives the illusion of comfort via a sense of independence and pride through their ability to maintain control (Faija et al., 2017). Although attachment style and ED responses are different in different contexts, all EDs are attempts to alleviate negative affect (Vögele, Lutz and Gibson, 2017). Extensive research suggests that those experiencing EDs are more likely to be blamed for their attempts to regulate affect and tend to be perceived as using the disorder for attention seeking, which further compounds feelings of shame (Ali et al., 2017). When a person's environment is filled with perceived threat and no secure support with which to manage affect, an ED may seem to be an understandable way for a person to obtain a sense of control (Vögele, Lutz and Gibson, 2017).

Object relation theory and attachment theory

Object relation theory focuses on how humans, from an early age, form internal representations of themselves and other people. For Winnicott (1971), there are 'transitional objects' and a 'transitional space' which provide a way of creatively moving from the internally constructed fantasy world to outer reality. In normal development, the nurturing and consistency of the mother provides a 'holding environment' which permits the child to commence piecing together its formerly unintegrated experiences of self and others (Bollas, 2013). However, traumatic experiences impact this capacity for moving from the internal fantasy to outer reality; as Kalsched (2014, p.35) explains: "repeated exposure to traumatic anxiety forecloses transitional space, kills the symbolic activity of creative imagination, and replaces it with what Winnicott (1971) calls 'fantasying.'" 'Fantasying' is a state of dissociation which uses the imagination as a defence to avoid reality and soothe anxiety.

When dissociation occurs, Winnicott (1965) explains that a 'false' and a 'true' self appear. The 'false self' emerges when there has been inadequate care and nurturance during developmental years and often adapts precariously to the world. This is linked to Fairbairn's (1952) theory of the divided self which contains a diverse array of non-communicating selves including 'the internal saboteur,' 'the rejecting object' and 'the persecutory object.' In Fairbairn's view, these aspects of the self have not been integrated into the psyche, therefore they remain unconscious, but need to be made conscious for healing to occur. Van der Kolk (van der Kolk and McFarlane, 2012, p.7) suggests that the inability to integrate a traumatic event or events into one's understanding of reality results in a "repetitive replaying of the trauma in images, behaviours, feelings, physiological states, and interpersonal relationships." These core issues are important in understanding not only object relation theory but also trauma and its effects; because when there is a failure to integrate an experience and accept it as part of one's past, it exists independently and becomes disassociated from one's conscious identity.

Using object relation theory, Kalsched (2014) suggests that a Jungian perspective of the archetypal universal images of myth and folklore can help individuals who have experienced trauma. Kalsched describes the dynamic and automatic nature of the deep level of psychological defence which tries to save the personal spirit as a self-care system. He explains (2014, p.1) that this "second line of defenses comes into play to prevent the 'unthinkable' from being experienced." The DSM-5 characterises these defences as psychopathological responses and defines them in various ways to help with treatment recommendations. Kalsched, on the other hand (2014, p.2), assumes a different approach and describes "the miraculous nature of these defenses, their life saving sophistication, and their archetypal nature and meaning." Although the self-traumatising inner voice encourages retraction from interpersonal relationships in maladaptive efforts to protect the individual from further pain, Kalsched (2014) is adamant that healing is possible through the stability of therapeutic relationships. Just as the mother provides a "holding environment" (Winnicott, 1971) which provides a sense of safety in the relationship, so too can church communities, by providing a safe space for those who suffer, to "work through their inner conflicts by means of creative play" (Hunsinger, 1995, p.26). The concept of play is essential to unleashing the curative

capacity in creativity and is expounded in Winnicot's "Playing and Reality," which will be further discussed in Chapters Five and Six.

2.1.3.3 Sociocultural factors and effects

Sociocultural risk factors

When conducting a meta-analysis on the existing literature, Doris et al. (2015) suggest that there is a substantial association between Western culture change and ED psychopathology. Media-orientated sociocultural factors influencing body image and EDs include magazines, television and films (Levine and Smolak, 2016). There has, however, been a more recent focus on the messages conveyed and images contained on social media (Hussin, Frazier and Thompson, 2011). A comprehensive examination of social media use has indicated that 'photo activity' is distinctly linked to body image concerns (Mabe, Forney and Keel, 2014). From a quantitative study of 438 adolescent girls, Tiggemann and Slater (2017) suggest that befriending and 'likes' in response to photos on Facebook, typifies a dominant sociocultural force impacting on body image. Furthermore, when examining the use of Instagram (Fardouly, Willburger and Vartanian, 2017) and Facebook (Tiggemann and Slater, 2017), this was specifically associated with greater social comparison and self-objectification. Standard interpersonal influences are also of particular importance socioculturally (Ata, Schaefer and Thompson, 2015). Sociocultural influence includes online organisations such as pro-ana websites, web-forums and social networks and although these organisations claim to exist mainly as a supportive environment for those in recovery they are widely recognised to advocate AN and BN as a 'lifestyle choice' (Norris et al., 2006). Pro-ana signifies to the promotion of behaviours related to AN, for BN there is a more infrequently used term of pro-mia (Norris et al., 2006). Furthermore, 'Thinspiration' is a widely recognised medium of endorsing these sociocultural aspirations through video montages or images of emaciated women, often with protruding bones (Norris et al., 2006). Within this culture there is a sense of the spiritual-ascetic, "The Thin Commandments" and "Ana's Creed" are also shared motivations to encourage weight loss (Norris et al., 2006). Negative sociocultural influences are recognised to be a major factor in the prolongation of EDs; however, experimental interventions have revealed that when women are encouraged to challenge these negative

influences and are supported by positive influences, levels of body satisfaction increase (Becker et al., 2017).

Gender and objectification

Macrocultural factors have significantly shaped the messages that women have received in Western cultures, which have culminated in gender-biased issues of body dissatisfaction and disordered eating (Grogan, 2016; Striegel-Moore and Bulik, 2007). Messages that communicate thin body idealisation are ubiquitous in all media. Women's magazines, in particular, much more consistently highlight the importance of body, diet and attractiveness when compared to men's magazines (Loeber et al., 2016). Diagnosis of AN and BN are almost ten times more typical among women than among men (PwC, 2015); this gender divide is normally attributed to body image based social-cultural influences which are traditionally more focused toward women than men. Carson (2003) suggests that, from childhood, many women feel external pressure to adhere to stereotypical roles created by a patriarchal society, in particular, adhering to the suppression of appetite to reach the desired image of bodily perfection. Historically, Boskind-White (1985) suggests that the cultural significance attributed to the social construction of sex roles should take sole responsibility for why EDs have become so pervasive.

For many women experiencing EDs, the 'perfect' body is desired and seen as a means by which she gains respect and consequently this externalisation results in objectification. Thus, their body does not feel like their own because it seems to be ruled by others around them (Carson, 2003). Fredrickson and Roberts (1997) suggest that women subconsciously adopt a habit of self-objectification in their efforts to attain culturally enforced ideals of beauty. They (1997, p.191) explain; "eating disorders are passive, pathological strategies, reflecting girls' and women's lack of power to more directly control the objectification of their bodies." Western cultural ideals often result in negative self-appraisal and subsequent feelings of shame and anxiety (Moradi, Dirks and Matteson, 2005; Dakanalis and Riva, 2013). Objectification theory asserts that culture defines emotional and behavioural responses to young women's views of their bodies (Fredrickson and Roberts, 1997). Self-objectification is now recognised to be a contributor to mental illness, including EDs. Register et al. (2015, p.107) explain that "[s]elf-objectification occurs when people internalize an observer's

perspective onto their own bodies." The dehumanisation of this internalisation can create feelings of shame, despair and helplessness (Rollero and De Piccoli, 2017). Various studies support the view that self-objectification causes an increase in eating pathology, depression and high levels of anxiety (Calogero, Davis and Thompson, 2005; Register et al., 2015; Moradi, Dirks and Matteson, 2005).

Fredrickson and Roberts (1997, p.188) explain the gender-specific nature of self-objectification: "having a female body, then, gives girls and women plenty to worry about and little to control." Women experiencing EDs often use methods of self-objectification as their core basis for self-evaluation, in an effort to control levels of self-esteem which is correlated with their perception of their body image. Fredrickson and Roberts (1997) quote Berger (1972) to explain self-objectification further. He articulates (1972, pp.46–47):

> A woman must continually watch herself. She is almost continually accompanied by her own image of herself … From earliest childhood, she has been taught and persuaded to survey herself continually. One might simplify this by saying: men act and women appear. Men look at women. Women watch themselves being looked at. This determines not only most relations between men and women but also the relation of women to themselves. The surveyor of woman in herself is male: the surveyed female. Thus, she turns herself into an object.

According to Fredrickson and Roberts (1997), danger is prevalent in sexual objectification because, as women internalise the objectification, they consequently self-objectify. Furthermore, Lindner and Tantleff-Dunn (2017) confirm that EDs and body image issues are linked to interpersonal sexual objectification in women. Piran and Teall (2012) emphasise that 'objectification theory' draws upon perceptions of embodiment which includes the relationship between one's body and mind as well as one's social environment. The disconnect often results in a sense of discomfort and approaching one's body like a stranger.

Susceptibility to shame

The most frequently identified barriers in thirteen research studies exploring perceived obstacles and facilitators towards help-seeking for EDs, are stigma and shame (Ali et al., 2017; NICE, 2017). Shame is an emotion which functions as a major risk and maintenance factor of EDs (Goss and Allan, 2014). The deep-seated feelings of shame experienced by those with

EDs about their behaviour, their efforts to manage it and low self-esteem, especially in comparison to peers, make the intractability of the disorder all the harder to address (Kelly and Carter, 2013). Duarte, Ferreira and Pinto-Gouveia (2016) suggest that social insecurity can be reinforced by shame proneness, as people with EDs often feel that they are defective and are not able to form social bonds with others. Therefore, recent literature has stressed the importance of analysing not only the relationship between shame-proneness and behavioural variables with a direct effect on the body, but also psychological effects (Doran and Lewis, 2012; Martin, Plumb-Vilardaga and Timko, 2014). Research reveals that shame is consistent between BN and AN, further underpinning that there are common transdiagnostic mechanisms and processes operating in both AN and BN (Franzoni et al., 2013). In a large clinical selection of ED clients, it was recorded that shame holds a pivotal role in the perception of a hostile self-image (Franzoni et al., 2013). Duarte, Ferreira and Pinto-Gouveia (2016) confirm this by showing that the effect of measuring self-worth by the external appearance causes an increase in external shame. Consequently, feelings of shame grow through unfavourable social comparisons, harsh self-monitoring and self-correction. S Szentágotai-Tătar et al. (2015, p.1) suggest that "[c]onsidering that shame and guilt are concerned with how one is being perceived and evaluated by others, these emotions may undergo important changes during adolescence." This suggests that adolescence is a period of particular vulnerability with regard to the potential to develop dysfunctional, shame-based processes of self-evaluation. Further literature on shame can be found in Appendix 6.

Identity

Research into women experiencing AN reveals that they understand their bodies as the only part of their life over which they can exercise control, and subsequently, as the ED rapidly escalates out of control, AN becomes their identity (Cornelius and Blanton, 2016). 'Pro-anorexia' communities which exist 'on-line' serve as an example of the deleterious and pervasive identity issues in AN which correlate higher levels of pro-anorexia identification with higher self-esteem and increased disordered eating (Cornelius and Blanton, 2016). Stein et al. (2013) insist that identity formation difficulties underpin the notorious emotion regulation difficulties of those who experience EDs. Research supports the case that those who do not achieve cohesive identity synthesis are located in a position of identity diffusion (Verschueren et al., 2017). Verschueren et al. (2017, p.26) suggest that "[r]esults indicate

that patients with ED experience more identity problems than community controls and those captured by an identity disorder status experience the most problematic psychosocial functioning." As Verschueren et al. (2017) explain, the consequences of identity diffusion are often chronic rumination which causes intense anxiety, feelings of low self-esteem and attachment insecurity, and this state hinders normal growth and formation. Corning and Heibel (2016, p.106) suggest that "[g]iven the downward trajectory and weaker identity formation associated with lowered self-esteem, healthy adolescent identity development should be a primary focus in prevention efforts."

2.1.4 Treatment of EDs and spirituality-based approaches

As recommended by the most recent guidelines published by NICE (2017), the psychological treatment for AN and BN in adults is eating-disorder-focused cognitive behavioural therapy (CBT-ED). For those primarily experiencing AN, the Maudsley Anorexia Nervosa Treatment for Adults (MANTRA), specialist supportive clinical management (SSCM) and eating-disorder-focused focal psychodynamic therapy (FPT) are recommended (Schmidt et al., 2016). These treatments typically consist of twenty to forty sessions over twenty to forty weeks (NICE, 2017). Furthermore, various forms of focused family therapy are recommended for children and young people for both those experiencing BN and AN; however, for adults this is less commonly recommended. The two general treatments recommended for those experiencing EDs are varied forms of psychotherapy and Cognitive Behavioural Therapy (CBT), in addition to these, novel experimental treatments are currently being trialled, including mindfulness-based interventions and compassion-focused therapy a review of these treatments can be found in Appendix 7. A further novel experimental treatment is spirituality-based approaches which will be discussed below.

Defining spirituality

In order to look at the relationship between spirituality and EDs, it is necessary first to define what spirituality is. Cook (2004, p.548) defines spirituality as:

> a distinctive, potentially creative and universal dimension of human experience arising both within the inner subjective awareness of individuals and within communities, social group and traditions. It may be experienced as relationship

> with that which is intimately 'inner', immanent and personal, within the self and others, and or as relationship with that which is wholly other, transcendent and beyond the self. It is experienced as being of fundamental or ultimate importance and is thus concerned with matters of meaning and purpose in life, truth and values.

In contrast to spirituality, religiosity is defined as a more extrinsic and institutionalised relationship with the sacred (Pargament et al., 2013). Religion is usually defined more in terms of beliefs and practices in faith communities where systems are agreed and held in common (Cook, 2013). However, quite often spirituality and religiosity are defined synonymously, as intrinsic spirituality is often dependent on religion. Marsden, Karagianni and Morgan (2007) postulate that religious beliefs such as the theological constructs of the illness have an impact on attitudes and motivation in EDs, so these cannot be ignored. Among many factors, positive religious coping is characterised by a relationship with God based on a sense of spiritual connectedness with others, security, and a belief that there is meaning and purpose in life (Pargament et al., 1998). Despite research confirming that women experiencing EDs are often distanced from their own sense of spirituality, spiritual interventions are rarely used in, or as an adjunct to, contemporary ED treatment programmes (Richards et al., 1997; Fogarty, Smith and Hay, 2016).

Spirituality-based approaches

It is now apparent in the medical and psychological healthcare sector that certain forms of spirituality and religiosity improve mental health (Dein et al., 2010; Vanderpot, Swinton and Bedford, 2017; Cook and Powell, 2013; Sims, 2017; King et al., 2013). In recent decades, academic and public consciousness regarding the relevance of spirituality and religion to health issues has increased. A considerable body of literature now exists on the need for collaboration between religion and psychiatry. This area is still in its early stages and is primarily focused on two areas: first, the training of psychiatrists and healthcare professionals in sensitivity to religious orientation, and second, co-opting faith-based organisations and their clergy to support mental health programmes. The World Psychiatric Association (WPA) affirms that there is a need for more research on both religion and spirituality in psychiatry, especially on their clinical applications (Javed, 2017). The Royal College of Psychiatrists' (RCP)

special interest group on spirituality is addressing this area in the UK (Dein et al., 2010; Vanderpot, Swinton and Bedford, 2017; Cook and Powell, 2013; Sims, 2017; King et al., 2013). However, in NI, Carlisle's (2015b, p.406) findings confirm that "while all of the service user participants expressed being aware of the role of spirituality within their experience of mental health, its exploration within mental health services was absent." Given that the conflict in NI was, and still is to a degree, intertwined with religious orientation, this absence is understandable, yet there is still an urgent need for a particular focus on the potential for a positive relationship between spirituality and mental health in NI specifically.

Spirituality and attachment to God

Contemporary research emphasises the value of a secure attachment to God as contributing positively to increased body satisfaction (Homan and Boyatzis, 2010; Homan and Cavanaugh, 2013; Strenger, Schnitker and Felke, 2016). Although preliminary findings appear positive there is a lack of specific research studies on EDs, religion and spirituality, as documented in Bonelli and Koenig's (2013) systematic evidence-based review. In response to this, Akrawi et al (2015) conducted a small systematic review of twenty-two studies and found that a secure attachment to God was consistently correlated with lower levels of disordered eating (Akrawi et al., 2015). Strenger, Schnitker and Felke (2016) suggest that if a woman has a secure base, this relationship is likely to help her to manage her emotions and therefore she is unlikely to use maladaptive coping mechanisms in response to negative affect. In Homan and Lemmons' (2014) study, an anxious attachment to God is associated with increased tendencies to engage in social comparison which consequently caused an increase in ED symptoms. Qualitative studies of recovered ED clients have found that, for many, spirituality has been crucial in their rehabilitation (Marsden, Karagianni and Morgan, 2007). In an intensive study of one ED client, a regulation of disorder behaviour was recorded to be linked to the resolution of distorted religious issues which were habitually misapplied to her life (Lea et al., 2015). In general, a secure attachment to God strengthens one's capacity to manage negative circumstances through meaningful relationships with God and others (Hall and Maltby in Bland and Strawn, 2014). Kaite's et al., (2015) meta-synthesis of those with severe mental illness, confirms that a secure attachment to God and a positive sense of spirituality are positively correlated factors in recovery.

When exploring the helpful and unhelpful aspects of religiosity on eating pathology and body satisfaction, Goulet, Henrie and Szymanski (2017) found that placing greater importance on religion was associated with increased eating pathology in the lives of 168 adult females at a Catholic-affiliated university. Studies suggest that an anxious attachment to God causes high levels of shame coupled with fears of rejection, which contributes to ED pathology (Akrawi et al, 2015). Homan (2014, p.977) explains, "people who feel uncomfortable depending on God, or who fear God's rejection, have difficulty extending kindness to themselves." Avoidant and anxious methods of relating to God therefore contribute to adverse outcomes (Hall and Maltby in Bland and Strawn, 2014). It is clear that religious affiliation is not always helpful, especially when beliefs become oppressive, but there is greater evidence to suggest spirituality could be a valuable aid in recovery. When analysing the findings from multiple related studies, Doumit et al. (2017, p.113) explain that "[t]hese studies indicated that individuals higher in spirituality/religiosity were not as overwhelmed by negative emotions because religiosity provided comfort, support, and hope in times of distress." Intrinsic religiosity is found to have a buffering relationship in decreasing the consequences of negative emotions and as a result can reduce ED symptomology. Doumit et al. (2017, p.113) explain that "[a]ffiliating as Christian was significantly negatively associated with ED vulnerability." Marsden et al. (2006) emphasise the importance of considering the religious and spiritual beliefs of those who experience EDs, as these fixed constructs can have a significant impact on behaviour, attitudes and motivation. Some authors (Richards et al., 1997) have theorised that those who experience EDs struggle with several core issues which derive from unresolved spiritual issues. They posit that a treatment method that considers spirituality could be the most effective way to address these issues (Richards et al., 2006).

Alternative forms of spirituality

Some preliminary findings express hope that yoga could be used as a novel, adjunct treatment to strengthen the effectiveness of existing models of multidisciplinary care (Pacanowski et al., 2017; Hall et al., 2016; Dittmann and Freedman, 2009). However, when considering the most recently published NICE (2017) guidelines for EDs, they are hesitant to use this as a treatment modality. NICE (2017) cautions: "Do not offer a physical therapy (such as transcranial magnetic stimulation, acupuncture, weight training, yoga or warming therapy) as part of the treatment for eating disorders." Therefore, although aspects of spirituality could be

particularly conducive to recovery, the use of yoga and other physical therapies may require caution. Despite a contentious relationship surrounding the inclusion of spiritual beliefs within mental healthcare, there is evidence to suggest that increased resilience exists in clients who embrace spirituality in a variety of forms as part of their treatment intervention (Carlisle, 2015a).

2.1.5 ED treatment in NI

Integrated care

The care pathway for treating EDs in NI recognises that treatment and care need to be personalised and 'recovery'-orientated, with the service user and professionals working together to determine a path to recovery (NICE, 2017). Literature documenting The NI Regional Care Pathway for the Treatment of EDs was launched in 2016 by HSCB (Health and Social Care Board) in accordance with NICE (2004) Guidelines CG9. The ED Care Pathway is accompanied by a 'Guide for People Using Eating Disorder Services' compiled by, and for, individuals who use the services and their carers. Furthermore, an information document for GPs was also launched to help encourage early referral. Beat (Eating Disorders Awareness Week (EDAW), 2017) also found that half of the respondents who experienced an ED and who rated GP care as "poor" or "very poor," 30% were not referred to mental health services after their appointment and only 34% said they felt their GP knew how to treat them. This is despite NICE (2017) guidelines that say patients should "receive treatment at the earliest opportunity." There is therefore an evident need for further help to enable the NHS to provide effective care and support for those experiencing EDs. More positively, Betts and Thompson (2017, p.4) comment that there is "better access to services in times of crisis." One of the main observations of the Mental Health Foundation (MHF, 2013) study, assessing the future of mental health services, was the fragmentation and lack of continuity between services. Ham et al. (MHF, 2013, p.21) observe that although the structures for integration are in place, "the integrated health and social care system has not realised its full potential and the opportunities provided by the structural organisation have not been fully exploited." Opportunities for growth point towards a more integrated and collaborative approach to provide adequate care for those experiencing EDs.

Community-based care

A specialist inpatient unit in NI for those experiencing EDs has been discussed for the past decade. This provision could be of great benefit to them and their carers and could reduce costs in the long term by cancelling out costs of being referred to England or the Republic of Ireland for specialist treatment. It is necessary to note, however, that increased resourcing of the community sector may be equally, if not more, beneficial. Lui et al. (2017) suggest that interventions which focus on socio-environmental determinants originating from the community, can address contributors to premature mortality. In assessing the potential for a specialist unit in NI, it was recommended (DH, 2016, p.16) that "[i]ncreased investment to enhance community-based eating disorder services could also improve the scope for better co-working with other mental health and medical specialisms." Furthermore, the Regional Eating Disorder Network (DH, 2016, p.16) also suggests that the service development priorities should be "[s]ustainable peer support/relapse prevention services with voluntary sector partners … [and] [s]ustainable support services for family members with voluntary sector partners." Community-based support from the voluntary sector is, therefore, the primary focus to help both those experiencing EDs and their carers. The RQIA (2015, p.24) confirms that "[a] number of families indicated that the EDANI service forms an essential lifeline for many people, as there are often waiting lists for specialist treatment." Thus, with increased funding, the community and voluntary sector may be able to bridge the gap and could potentially provide non-specialist support when specialist treatment is not immediately available, particularly in the waiting period between referral and treatment appointments. This is further supported by Betts and Thompson (2017, p.4) who explain that "[t]here is general endorsement for the strategic direction for mental health services delivered in the community as close to a person's home as possible." Therefore, Phase 1 (DH, 2016) concludes that the need for a specialist inpatient unit cannot be accurately assessed until the impact of fully- funded specialist community services is ascertained, as this may significantly reduce the number and duration of inpatient admissions required.

Holistic care

The Bamford Review Review (DHSSPSNI, 2007) has guided mental health service reform in NI over the past decade. There have been two Action Plans; 2009-11 and 2012-15. The Bamford

Review (DHSSPSNI, 2007, p.8) called for "a holistic, person-centred approach, which is respectful of the individual and delivered in a way that avoids stigma; services should be 'Recovery' focused … to empower people to achieve their potential and lead a fulfilling life." The four adult specialist ED teams in NI provide treatment in line with a model involving four levels of stepped care, as endorsed by the Bamford Review (2007), NICE guidelines (2004) and the psychological services model for mental health services recommended by the DHSSPS (2007). The aim of this stepped care model is to provide community-based treatment and prevent hospital admissions. Furthermore, within the Bamford Review (DHSSPSNI, 2007), there is a specific endorsement for clients with mental health issues to remain amongst their friends, family and communities to facilitate the most efficient and sustainable rehabilitation. It is notable that those experiencing EDs who have positive perceptions of family and community functioning have markedly better treatment outcomes (Holtom-Viesel and Allan, 2014). It is understood that church communities are often comparable to a family and can provide a similar support system. Furthermore, the recommendations of the report from Beat (PwC, 2015, p.9) propose that the key priority for further investment should include "funding holistic treatments that not only enable better treatment outcomes but also reduce the lifetime impact of eating disorders on the well-being of sufferers and their carers and families." It is clear that integrated collaborative pathways of care between clinical specialists and community-based organisations, including churches, could aid in providing more efficient support for those with EDs.

Religion, spirituality and mental health in NI

In NI there is notable reluctance to engage with religion and spirituality within mental health recovery, despite a significant number of Christian professionals involved in mental health support services. Consequently, such engagement is significantly under-examined within research and policy in NI, despite greater recognition and increasing empirical evidence supporting its use (Carlisle, 2016). Researching the concept of spirituality has been understood by some to be so complicated as to be best rejected and rather the study of religion deemed more feasible (Koenig, 2008). Furthermore, on a larger scale, service users testify that both spirituality and religion are very significant to them (McCord et al., 2004; MHF, 2002). Spiritual interventions, however, are rarely used in contemporary ED treatment

programmes, especially in NI, despite research confirming that these individuals are often distanced from their own sense of spirituality (Richards et al., 1997; Fogarty, Smith and Hay, 2016). Pargament et al. (2013) explain that due to the overlap between spirituality and religiosity, polarisation between the categories can result in many theoretical difficulties, and therefore both terms will be used throughout this thesis. As this area is explored in the context of church communities, pastoral care literature will be introduced in Chapters Two, Five and Six to develop the discussion and contribute to an understanding of the impact of religiosity and spirituality on ED care in NI.

2.1.6 Conclusion

As the quest continues for a biological trigger which prompts EDs, there is compelling observational evidence which suggests that those who experience EDs refrain from eating irrespective of the reality that most remain, (as Johnston (1993, p.30) describes), "ravenously, desperately, savagely hungry." Many suggest that the notably larger numbers of women presenting with EDs do not reflect any biologically distinct qualities which are only inherent in women. Rather EDs occur because of the impact of cultural norms regarding thinness that apply predominantly to women. The failure to meet unobtainable societal standards increases body dissatisfaction which results in body shame, and self-perception is then interpreted as defective, inferior or unattractive to others (Dakanalis et al., 2016). Although treatment methods have acquired a more recent focus on the role that sociocultural influences have on ED aetiology, maintenance and recovery, there is still much work to be done to make treatment interventions more effective (Kazdin, Fitzsimmons-Craft and Wilfley, 2017). The fact that many of those who have experienced EDs have a history of traumatic experiences (Brewerton, 2017) could be a preliminary evidence base for the therapeutic use of more MBIs which are particularly helpful for those experiencing feelings of disembodiment (Cook-Cottone and Guyker, 2017; Levine and Smolak, 2016). Although many women who experience EDs have found that spirituality has been helpful in their recovery, many women experiencing an ED report feeling distanced from their own personal sense of spirituality, and research suggests that there are significant factors contributing to this disconnect (Richards et al., 1997; Fogarty, Smith and Hay, 2016). Voice Two will explore this disconnect through

examining the core characteristics of those involved in fundamentalist movements. Furthermore, the possibility that there is an overlap between those experiencing mental illness and those involved in fundamentalism will also be considered.

2.2 Voice Two: Context of church-based culture – Fundamentalism literature review

2.2.1 Introduction

As interpretations of Christian fundamentalism have changed over time (Reid et al., 1990), scholars have deemed it increasingly difficult to define (Bebbington and Jones, 2013). In the past two decades research interests have increasingly focused on Islamic extremism and terrorism under the broader category of religious fundamentalism. However, for the purpose of this thesis, 'Christian fundamentalism' will be the focus, and because there is a limited amount of contemporary research on this area, literature which focuses more generally on religious fundamentalism will be used. Many of the factors of religious fundamentalism and Christian fundamentalism overlap, including the long-term contextual elements which cause fundamentalist movements to take root and burgeon. When studying this area, psychological factors have been important to consider as certain internal dynamics perpetuate both the fundamentalist movements' activities and, symbiotically, the core attitudes of those within the movements (Strozier, 2017). A discussion on Fundamentalism and mental illness is in Appendix 8. In this chapter, Christian fundamentalism will be defined in three key areas:

2.2.2 Defining fundamentalism

2.2.3 Fundamentalism in NI

2.2.4 Seven core characteristics of fundamentalism

2.3.2 Defining fundamentalism

In one of the most widely used definitions, Altemeyer and Hunsberger (1992, p.118) focus their interpretation on the cognitive processes and describe religious fundamentalism as

> [t]he belief that there is one set of religious teachings that clearly contains the fundamental, basic, intrinsic, essential, inerrant truth about humanity and deity; that this essential truth is fundamentally opposed by forces of evil which must be vigorously fought against and those who believe and follow these fundamental teachings have a special relationship with the deity.

Although fundamentalism is generally understood as an authoritarian expression of very conservative religious opinions, understanding catalytic contingent factors helps to understand the social construction of the movement.

The Fundamentalism Project (Marty and Appleby, 1991-1995) is a five-volume collection which strives to identify structurally analogous examples of fundamentalism in diverse traditions under the umbrella of social science. The general findings of similarities identified in fundamentalist movements through the Fundamentalism Project (Siven, Marty and Appleby, 1995, p.835) are as follows:

> a tendency, a habit of mind, found within religious communities and paradigmatically embodied in certain representative individuals and movements, which manifests itself as a strategy or set of strategies, by which beleaguered believers attempt to preserve their distinctive identity as a people or group.

As fundamentalists believe that their identity is at risk from the influences of modernity, they attempt to fortify it by holding fast to the fundamental tenets of their tradition in an effort to re-create a political and social order in accord with what they believe to be God's will. As Gschwandtner (2016, p.714) explains, "[f]undamentalism tries to construct and preserve identity – both personal and communal – in the face of a loss of identity or in response to what is perceived as threatening to that identity." Marty and Appleby suggest that there are nine characteristics that typify the majority of fundamentalists from the 'Abrahamic' faiths (in Clarke and Beyer, 2009). For the purpose of this thesis, seven of these characteristics will be used to frame Christian fundamentalism.

2.2.3 Fundamentalism in NI

Considering that one's religious beliefs have a significant influence on shaping emotions, thoughts, motivation and behaviours (Saroglou, 2016), it is important to note that in the 2011 census (Northern Ireland Statistics and Research Agency, 2011) NI had substantially more people stating that they were Christian (82.3%) than England (59.4%), Scotland (53.8%) or Wales (57.6%). Considering the fundamental principle of loving God, oneself and others,

Christianity should have a positive impact on mental health; however, fundamentalists who exhibit rigidity have lost the ability to self-reflect and have thus become incapable of showing authentic empathy, resulting in a lack of compassion and a more critical disposition (Strozier, 2017). Lifton (1999, p.14) suggests that fundamentalists' emotions can be as "fragile as they can be psychologically explosive," which inevitably feeds into their capacity to care for others in their community. Clear threads of fundamentalism are evident in NI (Blake, 2017). Consequently, there is a complex relationship between religious fundamentalism and mental well-being in NI and further investment into research in this area is important in helping to understand how fundamentalist beliefs may impact on mental health. As Carlisle (2015b, p.406) suggests, "research and policy development is required regarding how this subject [religion and mental health] is explored in contexts where religion is a site of conflict." This thesis seeks to explore whether the provision of more effective pastoral care in churches, alongside specialist medical care, could, by its cultural congruence, help to provide a more caring environment in churches for those experiencing EDs and their carers and alleviate the pressure on healthcare professionals.

2.2.4 Seven core characteristics of fundamentalism

As the study of Protestant fundamentalism is the context for this study, I will use Marty and Appleby's (in Clarke and Beyer, 2009) schematic description and core characteristics of fundamentalists condensed into seven core areas.

1. Reactivity
2. Selectivity
3. Moral dualism
4. Absolutism
5. Adherence to rigid boundaries
6. Authoritarian leadership
7. Adherence to behavioural requirements

2.3.3.1 Reactivity

The first characteristic of fundamentalism is what Marty and Appleby (1995) term as reactivity to aspects of modernity that fundamentalists see as posing a danger to their belief structure and organisation. Referring to Marty and Appleby's research, Frey (2010, p.9) explains that "[a] defensive or protective attitude toward religious belief is necessary, in their opinion, for a group or movement to qualify as fundamentalism." Fundamentalist leaders and their followers react against, defend against and innovatively find new ways to create a backlash against what they deem to be threats to the tradition that they would preserve. This reactivity to a perceived crisis is part of what Armstrong (2000, p.ix) describes as "a cosmic war between the forces of good and evil." In a similar vein, Marsden (1980, p.4) defines fundamentalism as "militant opposition to modernism," which connotes a war-time reaction against oppressive forces. Although violent extremism is more frequently associated with Islamic movements, Christian fundamentalism's perhaps less violent intolerance can nonetheless manifest in an aggressive psychological reactivity.

Lawrence (1995, p.6) notes that fundamentalists are in "opposition to all those individuals or institutions that advocate Enlightenment values and wave the banner of secularism or modernism." As fundamentalists react against modernism, they create a subculture which forms a protection against the relativistic products of the Enlightenment. Although fundamentalists react against modernity, the reality is that fundamentalism in itself is a product of modernity. Armstrong (2000, p.xiii) explains that fundamentalism's "symbiotic relationship with modernity" is not a return to premodern ways of being religious, rather it is a reaction to the failure of secular modernity. King (2008, p.15) writes: "[f]undamentalism mirrored Modernity's cerebral assumptions but lavished its scientific principles upon an agrarian biblos that modernism never mistook for science." Although fundamentalism rejects the ideology of modernity, it is birthed from modernity and adopts a modern scientific lens through which to view the Bible; thus fundamentalism attempts, but, (in the opinion of most external commentators), fails to attain credibility in its method. Armstrong (2000, pp.xiii-xvi) explains that the religious fundamentalist "confuses *logos*, a rational worldview or *Weltanschauung,* with *mythos*, a spiritual one." Secular modernity's efforts to nullify the existence of God is, of course, an understandable reason for fundamentalists to react against its influences. However, their efforts to compile scientific, Bible-based evidence to support

their claims cause further ostracisation from the secular rationalists. Despite the reasons fundamentalists give to support their position, this should not lead to an acceptance of or justification for their behaviour as a Christian response. As Herriot (2009, p.9) notes, "[w]e have to search for the origins of their reactionary fervour within our own understanding of its social and psychological context."

Reactivity has also been associated with hostility. Herriot (2007, p.6) describes reactivity as "hostility toward the secular modern world." Hostility is targeted towards anyone who is not part of the religious in-group; this may even include members of the fundamentalist's own religious group, including those who are identified as not being religious enough (Herriot, 2007; Hood, Hill and Williamson, 2005). Fundamentalists are reactive against lukewarm religious establishments, the secularising state and secularised civil society including the media and education. For the fundamentalist, these are viewed as corrupt, and those who accept them become definitively categorised as the 'out-group.' Social movements leading to potential social change such as racial equality, women's rights and scientific progress are included in the threat; for fundamentalists, any such movements which marginalise their beliefs are labelled as enemies of the faith. In a large meta-analytical study, McCleary et al. (2011, p.163) found that "[a]uthoritarianism, ethnocentrism, militarism, and prejudice" are linked to views which contend that there is an absolute religious truth, hence are commonly linked to religious fundamentalism. Marty (in Kaplan, 1992, p.19) further elaborates upon this, arguing that "[r]eaction, counteraction, revanchist action: these are characteristic. If they are not present, observers continue to call movements or cultures simply traditional or conservative." Ham's Creation Museum (Ham and Cardno, 1987) exemplifies the efforts at revanchist action in his deflection of scientific facts as heresy. Fundamentalists such as Ham seek to build symbolic walls; they embrace an enclave mentality resisting change and raising defences against perceived enemies and, in the process, isolate themselves from the rest of society.

Categorised as a resistance movement, adherents of fundamentalism seek to combat threats, whether perceived or real, to their traditional way of life; this inevitably requires a reaction as part of the very nature of the movement (Sargisson, 2007). Furthermore, Marty and Appleby (1994, p.1) explain that they are "fighting back against what is perceived as a

concerted effort by secular states or elements within them to push people of religious consciousness and conscience to the margins of society." To fight against the perceived threats of the world and to maintain and protect their perceived truth they must be rigid in their adherence to conformity, discipline and order (Hansen and Ryder, 2016). Fundamentalists notoriously use the imagery of warfare in fighting against the world, the flesh and the devil, emphasising separation from the secular world and their desire for a theocracy of perceived righteousness, using anger as fuel to perpetuate the battle. Bendroth (2016 p.342) insists that "[f]undamentalism survives today, especially in contemporary political rhetoric, as a deep sense of impatience [sic]. It is enough, if not everything, to shout at things, to denounce and deplore the sins of modern culture."

2.3.3.2 Selectivity

Almond, Sivan and Appleby state (1995, p.445) that "to explain fundamentalist movements means to show how structure, chances, and choice combine to determine their formation, growth and fate – and their shifting patterns of relation to the world." Fundamentalists are selective in which aspects of modernity they embrace, and which they actively target for rejection. Similarly, those who embrace fundamentalism are circumspect in the particular aspects of the tradition they adhere to and which aspects they dismiss. Their agenda regarding selection and dismissal is positioned in opposition to the perceived threat of worldly influences. Almond, Appleby and Sivan (2003, p.99) note that "[s]electivity revolves around the need to pare down the tradition to the essentials because of the danger that it faces." For fundamentalists, tradition is modified into a systematic ideology and each decision as to what is accepted and what is not, changes with time. Although this does allow a certain gradual evolution of fundamentalism as a movement, it also reveals the selectivity and the bias of those who modify fundamentalist tradition. When viewing fundamentalism in historical terms, the absolutes which were so vehemently held have changed and continue to change. Among the most culturally-related aspects are attitudes towards television, cinema, clothing and makeup which serve as examples of things that are now less often prohibited than they used to be in fundamentalist communities.

More contradiction becomes apparent, as Herriot (2008, p.178) explains: "[t]he ultimate outcome of contradictory behaviours is that every triumph that is praised by the world is, in fact, a failure; and, conversely every apparent failure by fundamentalists is, in fact, a triumph." The self-esteem of the fundamentalist is therefore enhanced by the disapproval of the world and by the approval of like-minded comrades. Fundamentalists reveal the importance of retaining the uniqueness of their identity through vigilance in separation from certain influences of modernity, and their reactivity to anything which might potentially contaminate that identity. Attempts to strengthen their identity by retrieving certain sacred convictions, practices and doctrines thereby reshape or reinvent particular aspects of the tradition to further distinguish fundamentalists from those belonging to mainstream religious groups (Almond, Appleby and Sivan, 2003).

Almond, Appleby and Sivan (2003, p.102) suggest that "[t]he companion to selectivity is inerrancy. In a doubting and cynical world, one needs sure proof. The doctrines are not only clear cut, they are of divine origin and are true beyond doubt." Ruthven (2007, p.52) finds that the term 'fundamentalist literalism' lacks utility; rather he suggests a more precise definition of fundamentalist literalism as pertaining "not to textual exegesis, but to literal interpretations of certain formulations and concepts." Christian fundamentalism could be condensed to encapsulate the view that humans must surrender to and obey God's commands because the Bible is certifiably inerrant. This is not to be confused with the infallibility of God to which mainstream Christians adhere, in that God is Himself without fault. Clarke and Beyer (2009, p.210) further explain that "[t]he Bible can function almost totemically in some communities, while in others it provides illumination, inspiration and canonicity – but it is rarely read or regarded as wholly inerrant." Historically, however, Warfield (1927) was committed to the defence of biblical inerrancy, infallibility and inspiration. Inspiration, he comments (1927, p.396), "is that extraordinary, supernatural influence (or, passively, the result of it) exerted by the Holy Ghost on the writers of our Sacred Books, by which their words were rendered also the words of God, and therefore, perfectly infallible." For many fundamentalists, inspiration is synonymous with dictation (Hamilton, 2014).

Mohler (2013), one of the most zealous upholders of the doctrine of inerrancy, insists that inerrancy is not only central but also essential. Thus, according to this view, the Bible, in its original documents, comes directly from God, flawlessly put into the minds of men who then perfectly reiterated this acquired knowledge. As Mohler (2013, p.58) insists, "[w]hen the Bible speaks, God speaks." While it is evident in the Hebrew Bible that the "Word of God" meant not words on a page, but a special message from God to a recipient, usually a prophet, Hodge (in McGrath, 2016, p.113) claims that this does not diminish infallibility: "[t]he Holy Spirit … rendered … the minds of certain selected men the organs of God for the infallible communication of his mind and will." There is no room for mythological interpretation or an appreciation of the subjective nature of interpretation; objectivity is an absolute necessity. Todd (2012, p.3) explains that fundamentalism is

> literalism in interpreting the scriptures of any religious tradition as history rather than as mythology and metaphor expressing universal or archetypal themes of timeless significance for humankind's understanding of its origin, future destiny and significance in cosmology.

McDonough (2013) suggests that the fundamentalist's presupposition of indirect or direct communication from God is unjustifiable. He argues (2013, p.561) that "religious fundamentalism, understood, roughly, as the view that people must obey God's commands unconditionally, is conceptually incoherent because such religious fundamentalists inevitably must substitute human judgement for God's judgement." Thus, the closed-mindedness of fundamentalists is clearly distinctive by their consistent deference to God and is used as a cloak for intolerance (McDonough, 2013). As an example, Creationism could be described as an unwillingness to give up a dogmatically held position despite scientific evidence to the contrary.

2.3.3.3 Moral dualism

The dualism between good and evil has existed as a central belief in many historical traditions and sects of Christianity, including Marcionism, Catharism, Paulicianism and Gnostic Christianity. Within these sects, the enemy is categorised as dividing the world into evil and good. Morris (2008, p.95) notes, "Gnostics and fundamentalists agree that the material,

physical world is evil and irredeemable. Matter cannot be justified or remedied. Materiality is denounced; spirit is good. Only the spirit can overcome evil." Kunst and Thomsen (2015, p.305) explain that "[t]he fundamentalist mindset encompasses the traditional triad of the world, the flesh and the devil, resulting in impaired socio-emotional development and hostility to one's body." Furthermore, Herriot (2008, p.177) states that "[t]he dualistic distinction between the supernatural world of the spirit and the sinful world of the flesh, shapes the social identity of Protestant fundamentalists." Morris (2008, p.108) claims that Gnostic and fundamentalist beliefs are intertwined, in that they both make efforts to escape from the physical body as they both maintain a "deep distrust of the body and its functions." Morris (2008, p.108) writes:

> The emphasis was upon denial of pleasure. To engage in pleasure meant contamination of the spiritual self with the physical body, a mindset and practice followed by the ancient ascetic Gnostics. ... They are unable to bring a theology of incarnation home to the human body.

Although self-flagellation and other displays of mortifying the flesh have largely vanished in twenty-first century Christianity, fundamentalists still associate holiness with a denial of pleasure. This behaviour of self-denial, combined with the polarisation of pleasure and purity has led many ex-fundamentalist Christians to seek psychological help (Jones, 2016).

Woodberry and Smith (1998, p.29) explain that although Christian fundamentalism is described as evangelical, the importance of authoritarian leadership makes the desire to "[c]ome out from them and be separate," based on 2 Corinthians 6:17, more of a literal demand than that of evangelical Christianity. Marty and Appleby (1994, p.1) further posit that fundamentalists have chosen to "separate from fellow believers and to redefine the sacred community regarding its disciplined opposition to nonbelievers and lukewarm believers alike." Psychologists who study fundamentalism point to dualistic thinking as its core characteristic to such a degree, according to Strozier and Boyd (2010, p.14), that "… the centrality of binary oppositions defines the fundamentalist mindset." Fundamentalists are predisposed to divide the world into comprehensible binary distinctions; right or wrong, good or bad, with us or against us. Kenny (2015, p.157) suggests that "the defence of splitting makes the polarisation between us (in-group, all good doing God's will) and them (out-group,

all bad and doing the work of Satan) possible." In psychoanalytic theory, splitting, as popularised by Freud and Klein, is the failure in one's psyche to integrate the dichotomy of negative and positive characteristics of oneself and others into a cohesive whole. Kenny (2015, p.183) writes, "splitting intensifies when the bad experience becomes overwhelming and unmanageable. The bad object is repressed (i.e. removed from consciousness) but its influence results in a rigidity of mind and fundamentalist thinking." People who have become overwhelmed by negative experiences have become rigid in thinking, lost the ability to self-reflect and thus become incapable of showing authentic empathy, resulting in a lack of compassion and a more critical disposition. As Armstrong (2000) explains, fundamentalists subscribe to a black-and-white worldview that divides the world into enemies and fellow defenders, and takes a vow, however unrealistic, to accept no shades of grey. Almond, Appleby and Sivan (2003, p.95) state that, for fundamentalists, "the world outside is contaminated, sinful, doomed; the world inside is a pure and redeemed remnant." Bruce (2000, p.110) explains that this is why and where the 'blame' mentality comes from; "bad things occur because bad people desire them," therefore enemies are created, differences are illuminated as threatening, and negative distinctions are made.

Strozier et al. (2010, p.14) suggest that "dualistic thinking causes one to 'see others in very partial terms – as part-objects,' such that fundamentalists 'lose the ability to imagine the inner humanity of others.'" To explain this phenomenon Dykstra (2014, p.614) writes, "[f]undamentalists … have a difficult time experiencing empathy. Fundamentalism becomes an exercise in failed empathy, in lacking the capacity to imagine others' inner lives." The lack of empathy and ability to disconnect from emotions is characteristic of all who engage in fundamentalist movements. Maltby (2013, p.10) explains that "the stern piety of fundamentalism rules out compassion for those left behind." Genuine compassion is often conditional in the lives of fundamentalists whereby the unity among the 'in-group' breeds a family allegiance, but the vehemence and often hatred against the 'out-group' is justified and supported by their interpretation of scripture. However, the lack of compassion and the callousness against unbelievers can be understood from a psychological perspective. Saroglou (2016, p.34) explains:

> religions preach compassion and altruism; therefore, religious conflict and prejudice should be attributed to 'human nature' – or, in psychological terms, to underlying personality factors other than religiosity, such as authoritarianism or cognitive rigidity, or even to socio-demographic variables such as low education.

One of the principle differences between generally religious individuals and religious fundamentalists, is cognitive rigidity which diminishes one's capacity for conceptual thinking and openness to new experience (Zhong et al., 2017). Although fundamentalists use the Bible as their rule book, the militant and coercive nature of fundamentalism is not a fundamental tenet of Christianity (Dykstra, 2014). Rather, the fragmented psyche of fundamentalists misunderstands the primary message of scriptural teaching and misuses it to create division rather than unity. In this dualistic position, an illusion of safety is created by a community of like-minded and often equally-fragmented 'believers,' wherein the fear of threat and annihilation from the 'out-group' quite often increases the strength of their resistance (Strozier et al., 2010).

2.3.3.4 Absolutism

Fundamentalism usually indicates unwavering, rigid attachment to a set of irreducible beliefs defined as absolutism (Nagata, 2001). Barr (1978, p.11) argues that fundamentalism is "based on a particular kind of religious tradition, and uses the form, rather than the reality of biblical authority to provide a shield for this tradition." As Barr (1978) explains, fundamentalists are highly rationalistic in their belief system wherein there is little room for probabilities, nuance and qualification. Armstrong (2000, p.371) identifies that fundamentalists seem to be "trapped in an escalating spiral of hostility and recrimination" as they try to fill the God-shaped hole by seeking absolute certainty in strict, inerrant doctrinal correctness, modelling themselves on past ideals of an elusive Golden Age. Fundamentalists are often driven by the need for certainty. Bruce (2000, p.110) states that "[f]undamentalists have little time for the idea of unintended consequences. If things happen, they must have meaning and meaning is found in the intentions of the agent who caused the act." This not only feeds into the need for certainty, but also explains the propensity for a leaning towards "decoding signs and discovering hidden connections" (Bruce, 2000, p.111). These are foundational tenets within

a fundamentalist's worldview that are predicated on a sense of special status and destiny (Barr, 1978) and, ironically, highly characteristic of the modern, scientific approach.

Strozier and Boyd (2010, pp.11-12) suggest that "the need for simplified meanings and most of all for the absolutist and totalized way things get structured in the fundamentalist mindset" is amongst its most remarkable features. As traditional premodern Christianity provided ontological security, fundamentalism seeks to resurrect this security through asserting an absolute formula of truth which has no regard to consequence (Giddens, 1994). Hill and Williamson (2005, pp.17-18) claim that "[f]rom a psychological perspective religion's lure for many is that it provides moral certainty and stability, thereby contributing to a sense of coherence in an otherwise chaotic world." Fundamentalism provides indoctrination and a belief that religion can provide definitive answers to one's ontology and epistemology, including questions of mortality. This subsequently provides a feeling of purpose and a lens through which to understand and therefore a sense of clarity to life (Vail et al., 2010). Kenny (2015, p.157) paradoxically suggests that "[a]dherents are no longer denigrated and alone but exalted as a select and chosen few. … Gone is the hopelessness and uncertainty in life; the path is straight, and the goals are clear." For fundamentalists, diverting even slightly from the absolutist beliefs can be seen as a mortal sin and may have a destabilising effect as it threatens individuals' identity and therefore their sense of safety (Dovidio, Gaertner and Saguy, 2007, Kossowska et al., 2016).

Gschwandtner (2016, p.714) argues that "[f]undamentalism tries to construct and preserve identity – both personal and communal – in the face of a loss of identity or in response to what is perceived as threatening to that identity." The distinctive fixed identity of fundamentalism is attractive, in contrast to the lack of security which is related to modernity's relativism and postmodernity's emphasis on plurality and globalisation (Ruthven, 2007). To the fundamentalist, this illusion of security is provided by a clear demarcation of boundaries. Herriot (2014, p.107) suggests that "[i]f the most powerful human motives relate to the security, maintenance and enhancement of the self, then the social identity of fundamentalist adherents provides extraordinarily powerful motivation." A sense of belonging is a foundational element of fundamentalists' self-concept which functions to shield them from

the ambiguities of life (Lassander and Nines, 2016). Aldridge (2007, p.131) writes: "[f]undamentalism, so called, is a possible haven, though a precarious one."

2.3.3.5 Adherence to rigid boundaries

Those in fundamentalist movements rigidly strive towards absolute certainty in strict, inerrant doctrinal correctness, driven by fears of being deceived by the wiles of relativism. Altemeyer, Hunsberger and Paloutzian (2005, p.382) describe fundamentalist beliefs as a form of "dogmatism, defined as relatively unchangeable, unjustified certainty." By demarcating differences between their religion and others, fundamentalists' coping strategies involve creating religious boundaries (Pargament, Koenig and Perez, 2000). The boundaries guard against relativising the absoluteness and infallibility of one's own, God-given, religious meaning system (Kunst and Thomsen, 2015). Fundamentalists forcefully refuse to accept that there are other ways to understand the world (Wrench et al., 2006). Blogowska and Saroglou (2011, p.57) argue that "religious fundamentalists often go further than mere religious people in out-group derogation, showing hostile attitudes and behaviors." These restrictive boundaries can breed resentment and fear, while also nurturing judgmentalism and prejudice even directed towards those in the in-group who do not adhere to the boundaries set. Furthermore, Herriot (2007) advocates that self-esteem may also be enhanced through the comparison of the self with those in the out-group who do not adhere to the high standards set by the in-group. The closed-mindedness against those whose values and orientations digress from the tenets of fundamentalism causes a heightened defensiveness and an irrational sensitivity to critique. They have assumed a defensive position in relation to society as a whole. Their efforts to fight back are exemplified by their high defensive walls and rigid boundaries designed to keep the out-group out and the in-group in. Supposed safety is therefore created through well-defined boundaries, demarcating and ordering human experience according to a rigidly defined moral code.

Phillips and Ano (2015, p.300) explain that "fundamentalists are isolationists with clear rules to follow, drawing sharp distinctions with those outside their religion." Admitting that their religion has, even to a certain extent, the same doctrinal foundations as other religions would be unthinkable to most fundamentalists. As a consequence, they often segregate themselves

into silos. However, the inter-dependence of the individuals who reside in fundamentalist silos provides a strong collective identity that consequently edifies their beliefs. By maintaining a seemingly impenetrable boundary between their community and the 'secular' world, fundamentalists develop a sense of safety, often alongside a fear of life outside these rigid boundaries. As the sense of containment is linked to binary thinking, McDonough (2013, p.574) explains that "the fundamentalist sees the meaning of God's communications as clear and straightforward." Herriot (2007) and Hood et al. (2005) suggest that Christian fundamentalists create strict rules to follow in order to stay within the sharp boundaries they have set, which ultimately results in divisiveness, segregations and elitism. Imam, Golak and Marler (2017, p.28) suggest that "[f]or those feeling alienated, religious fundamentalisms appeal precisely because of their certainty, their clear roles, and definite answers to complex problems." However, when fundamentalists discover that they are unable to successfully adhere to the rigid boundaries or constantly 'keep the rules,' they often consider themselves to be inept or worthless and internalise failure as shame (Strozier and Boyd, 2010).

2.3.3.6 Authoritarian leadership

Militant, institutional and authoritarian leadership is a hallmark of religious fundamentalist movements. Armstrong (2001, p.xiii) explains that those who are part of fundamentalist movements "have absorbed the practical rationalism of modernity and under guidance of their charismatic leaders are [fighting back] to re-sacralise an increasingly skeptical world." Allegiance to a charismatic leader is a significant characteristic of authoritarian leadership. Lifton (1999, p.14) explains that charismatic leadership includes the "ability to instill and sustain feelings of vitality and immortality, feelings that reach into the core of each disciple's often wounded, always questing self." When an ideology is presented before those who are vulnerable, there is often a desire for safety and purpose driven by personal insecurity. Lifton (1999, p.19) further indicates that "intense personal conviction is essential to the guru's success. However, that conviction can be helped considerably by grandiose ambitions and manipulative inclinations." Herriot (2008, p.177) outlines the manipulative inclinations suggesting that charismatic leaders are often partial to "political influence, financial rewards, and status gained by their own celebrity and their reflected glory from that of others." He also indicates that the recent growth of prosperity theology amongst fundamentalists reveals

the realisation of the need to rationalise what would otherwise be described, with hostility, as worldly behaviour. Lienesch (1993, p.45) notes there is often a "dangerous ambiguity towards the sinful world of the flesh." The parameters of this are set through the charismatic fundamentalist leaders who are selective as to which aspects of the sinful world they resist and which parts they participate in and engage with.

Fundamentalism is notably related to other attitudes such as right-wing political authoritarianism. Altemeyer, Hunsberger and Paloutzian (2005, p.386) argue that "[r]ight-wing authoritarianism is defined as the covariation of three attitudinal clusters in a person: authoritarian submission, authoritarian aggression, and conventionalism." Ammerman (1987) is particularly concerned with both the power of fundamentalists and the limits of what fundamentalists hope to achieve in a pluralistic society. She indicates (1987, p.4) that "[c]ompromise and accommodation are among the most dreaded words in the fundamentalist vocabulary." Misuse of power through domination notoriously culminates in fear-motivated adherence to rules in fundamentalists.

The strict conformity to authoritarian leadership temporarily reduces cognitive dissonance (Hunsberger et al., 1996); that is, the mental distress caused by holding two or more contradictory beliefs. Kenny (2015, p.156) argues that the embrace of fundamentalism is enabled by:

> a failure of introspection, that is, an unwillingness or incapacity to think for oneself, a denial of a space within for self-reflection that occurs in a situation in which external reality is so chaotic and destructive as to overwhelm one's emotions and ability to think because one's capacity to bear the anxiety or distress of one's situation has been exceeded.

Thus, involvement in fundamentalism could be driven by a psychological desire for strong leadership and direction. Kruglanski and Webster (1996, p.103) have coined the descriptive term: "[a] need for cognitive closure" as a strong desire to veer away from uncertainty and a strong need for unambiguous conclusions. Milyavsky, Kruglanski et al. (2017) link this aversion to ambiguity and desire for certainty to arrogance and dismissiveness. When this tendency is combined with a decreased motivation to think constructively, individuals often

require authoritarian leadership to firmly lead them into an uncertain future (Schumpe et al., 2017).

Through developing insights from Freud (1927) and Foucault (1977), Butler (1997, pp.6-7) introduces ideas associated with fundamentalist beliefs as being formative of someone who has a "passionate attachment" to their own subordination. When considering existential dilemmas which affect all of humanity, Giddens (1991, pp.181-208) identifies that the choice between uncertainty and authority is one of the "tribulations of the self." With a strong element of generalisation, Kenny (2015) claims that those who are vulnerable to the fundamentalist message are those who have experienced trauma and have attachment issues culminating in identity diffusion, and therefore are searching for a group to give them a sense of self.

2.3.3.7 Adherence to behavioural requirements

The rigid moralism that is common to fundamentalists usually revolves around specific aspects of human behaviour. Conforming to a fundamentalist group usually involves adhering to specific rules and regulations, including surrendering how one spends one's time and resources. This methodical process is sometimes referred to as the adoption of casuistic ethics (Jonsen, 1995), and provides a strict code of moral conduct which does not require an individual conscience. In fundamentalism, as Vorster (2008, p.50) explains, often the core characteristics of behaviour are based on an abuse of casuistic ethics which "deny the individual the right to freedom of choice when it comes to the management of their behaviour and conduct."

Although some fundamentalists have managed to manoeuvre round the Apostle Paul's insistence regarding head covering for women in church (1 Cor 11:2-16), they generally refuse to see Paul's proscriptions around silence and submission (1 Tim 2:11) as being culturally conditioned. Consequently, fundamentalists who hold these beliefs assert the authority of the patriarchal system and propound the validity of traditional gender roles. Hawley (1994, p.49) explains that "fundamentalist women are expected to be submissive, to demand no voice of authority in the church or in the home." Although Hawley was outlining the position

of Christian fundamentalists over twenty years ago, the patriarchal demand for submission still dominates many fundamentalist churches, families and some schools where strong views on submission are held regarding the necessity for authoritarian-based disciplinary action, including corporal punishment (Perrin, Miller-Perrin and Song, 2017). This tyranny is understood as a behavioural requirement, originating from a literal interpretation of the scriptures rather than an oppressive force that coerces women into a position of powerlessness (Auga et al., 2013).

As a response to the decadence of the 1960s, there was a reaffirmation of fundamental religious and social beliefs; a modern religious revivalist movement then became the catalyst for a significant counteraction against feminism (Almond, Appleby and Sivan 2003). DeBerg (2000) was among the first to outline the social characteristics of resistance to changing gender roles in fundamentalism as a reassertion of patriarchal authority in response to the rise of feminism. According to DeBerg (2000), the movement was concerned to return to earlier, more primitive views about women. As Bebbington (2013, p.7) outlines, "[t]he relations between the sexes, on this understanding, were seen by fundamentalists as symptoms of a declining moral standard that had to be regulated." In Bendroth's (1993) claims that, as fundamentalists began moving away from perfectionist theology and adopting dispensationalism, a collective view regarding the subordination of women began to move to prominence. Bendroth (1993, p.41) explains the historical context; she writes, "[d]ispensational pre-millennialism embedded the principle of masculine leadership and feminine subordination in salvation history itself and, perhaps more important, uplifted order as the highest principle of Christian life and thought." Dispensationalists taught that original sin was irreversible, in contrast to perfectionists, who believed that one had the power to resist and overcome sin; therefore, when connecting this to the creation narrative and the fall of humanity, the subordination of women was considered unavoidable. Reid (2013, p.154) summarises, "[f]emale subordination was traced to the Fall, which confirmed women's weak nature and legitimized their subordination."

Although fundamentalism is commonly thought of as universally pioneered and dominated by men, it is evident that both men and women choose to adopt patriarchal constructions of individual and collective identity in a community (Korb, 2010); submissive attitudes are not

always enforced by men but are sometimes the chosen behavioural position of women. As Bebbington (2013, p.7) explains, on this understanding, the relations between the sexes were seen by fundamentalists "as symptoms of a declining moral standard that had to be regulated." Generally, fundamentalist groups have tended to idealise patriarchal structures of authority or morality and share an advocacy of a God-given or 'natural' gender dualism (Friedman and Jack, 2017). Imam, Gokal and Marleruse (2017, p.17) refer to the pervasive problem as "the reinforcement of male authority and rigid, heteronormative, and patriarchal gender relations." Furthermore, as Bendroth (1993, p.19) highlights, "[f]undamentalism claimed the most effective cure for ailing masculinity. Its defenders insisted that it alone offered the challenge men sought and that liberalism was a spineless alternative." The authority and respect endowed on fundamentalist leaders, who are almost always male, has, as Bendroth (1993) explains, a unique appeal for certain types of men who are quite often attracted to exercising power over the vulnerable.

De Beauvoir (1952) in 'The Second Sex,' raises core issues concerning female embodiment, including how religious fundamentalism can oppress and influence women's attitudes toward their own being when considering their right to freedom. De Beauvoir (1952, pp.xvi-xviii) epitomises the view that "[t]hroughout most of the world, women play the role of the designated other therefore they tend to characterise and carry the projections of all that is threatening and undesirable in human existence, including sexuality, sin, and mortality." MacArthur (2006), on the other hand, advocates female subordination as being a necessary behavioural requirement for all who profess to be Christians, as explained in his work, 'Divine Design: God's Complementary Roles for Men and Women.' He writes (2006, p.42), "[w]hen a wife is not submissive, not following but resisting, pouting, naming, crying, wanting her way, whining, and often the husband does give in, there will be disharmony and discordance in the home and his leadership will be undermined." This excerpt would suggest that according to a creational order, males are viewed as superior, and women should be submissive as a way to uphold God's structures of morality and authority (Reid, 2013).

2.2.5 Conclusion

The rigidity in the overarching meta-system of fundamentalism controls not only its own religious domain, but also a range of attitudes, beliefs and practices. This rigidity feeds into a

mindset of out-group derogation (Blogowska and Saroglou, 2011) which has a symbiotic relationship with closed-mindedness and a consequential lack of creativity (El-Haq, Abdelaziz and Mohamed, 2016). Those who have rigidity in their thinking style and a strong need for 'cognitive closure' tend to accept any belief or position and employ stereotypes, provided that they reduce ambiguity and minimise the amount of cognitive work necessary for making decisions (Shumpe et al., 2017). Therefore, it would seem that authoritarian leadership is not merely submitted to; it is rather sought out and desired. Marty and Appleby (1994) repeatedly found that foundational to the behavioural requirements of fundamentalist groups is a patriarchal system deeply woven into the fabric of everyday life, defined as men leading, and women and children following. Despite the contentious relationship between mental illness and fundamentalism, evidence would suggest that religion and psychiatry should not be divorced from one another; rather, in appropriate contexts, both have potential to contribute to good pastoral practice (Cook, 2013). Furthermore, as character formation is socially constructed, sociology has much to contribute to the conversation on pastoral practice which is further evidenced in the following section presenting Voice Three: Pastoral care.

Voice Three: Context of care – Pastoral care literature review

2.3.1 Introduction

Pastoral care may be defined as the emotional and spiritual support present in all traditions and cultures. Historically, in Western societies, the term 'pastoral care' has Christian roots. However, the pastoral care movement has enlarged to envelop many different faiths and secular contexts. Clebsch and Jaekle (1994, p.4) classically define Christian pastoral care as "[h]elping acts, done by representative Christian persons, directed toward the healing, sustaining, guiding and reconciling of troubled persons whose troubles arise in the context of ultimate meaning and concerns." This definition has been developed by Clinebell (1970) as he emphasises the importance of 'nurturing'; by Lester (1995) as he accentuates 'liberating', and Campbell (1981) as he underscores the importance of 'loving' in the pastoral relationship. In essence, in the pastoral tradition, God is recognised as the primary carer from whom all love flows; energising and motivating human care and initiative throughout the ages. In this section, four specific areas will be addressed:

2.3.2 Emotions and pastoral care

2.3.3 The pastoral carer

2.3.4 An overview of literature on pastoral care and EDs

2.3.2 Emotions and pastoral care

2.4.2.2 A pastoral theology of emotions

McClure (2011) presents a pastoral theology of emotions as a classification of human experience, crucial to interconnected life, based on an interdisciplinary review of the literature on emotions. McClure (2011, p.188) believes that "[e]motions are cultural artifacts that locate us within interpersonal relationships and particular cultural contexts." This socially orientated theoretical view of emotions disputes the perspective that our affective state is innate or determined before social engagement (Harre and Parrott, 1996). If an emotion such as anger is suppressed, Lester (2003, p.3) contends that it can become "so intense that it bursts forth in destructive ways, leaving feelings of guilt and shame, and reinforcing the idea that anger is bad." Campbell (1981) describes the destructiveness of unexpressed anger when he suggests that, in pastoral care, anger has been viewed as

undesirable, something best avoided, or if unavoidable, at least minimised. Beverly Harrison (1996, p.8), drawing from her ground-breaking essay "The Power of Anger in the Work of Love," writes;

> All agree that anger is not only a disposition but a relational dynamic and in no way the deadly sin of classical tradition. Feminist theologies all but unanimously reject the patriarchal definition of life as involving "sacrifice of self and refuse the notion that the self-assertions involved in the expression of our passions, including anger are "wrong".

Harrison (1996) explains that anger is to be understood in the context that it is a signal that all is not well in our relation to other persons or groups, or to the world around us, but rather signals a sense of connectedness but also the energy to act.

Campbell's (1981) discourse on the enigma of a passionately loving and passionately angry God presented in the Bible is an inquiry into the value of anger. However, Lester (2003, p.218) does recognise that "[i]f separated from love's guiding light or foundational principles, anger's destructive powers will lead us into unethical behavior even as we try to confront unethical behavior." Nevertheless, in normal human situations, he shows that anger can be useful in stimulating political action and so becomes a valuable resource for the church's prophetic ministry of transforming oppressive human environments. He (2003, p.176) further affirms that, when anger is an appropriate response to a fitting circumstance, it protects and preserves one's "physical, mental, and spiritual health." Anger must be understood as part of the full spectrum of human emotions and a God-given gift, essential to human flourishing, though it is important to remark that particular care must be taken to frame anger within the bedrock of broader Christian principles.

Embodied emotions

McClure (2011) identifies that emotions are also somatically felt, that they motivate behaviour, and that they have energy and power that need to be expressed and regulated. Neuropsychology affirms the embodied nature of emotions which contributes significantly to the quality of experiences, relationships and imaginative possibilities (Whitehead, 2016). In the same way that misdirection in the expression of emotions can be dangerous, the suppression of emotions is notoriously dangerous and can have significant implications for

well-being and one's sense of spirituality. Just as psychology asserts the embodied quality of human emotions, so too should theology. A theological anthropology that places value on human emotion is essential as Whitehead (2010, p.262) explains:

> As theological creatures embedded in relational systems, emotions can be understood as adaptive and not inherently life-limiting; moreover, they contribute a measure of passion, direction and possibility to the reciprocal interactions of the divine-human relationship.

Emotion is integral to embodied human existence and must be taken seriously. Therefore, Christian pastoral care must engage with all features of the emotional lives of individuals. Lyall (2001, p.xvii) asserts that genuine pastoral care has "theological integrity located in biblical narrative." It is crucial that the full spectrum of emotional experience as documented in the biblical narrative, is respected and drawn upon to facilitate authentic pastoral care.

The practice of pastoral care and awareness of emotions

McClure (2011) identifies that emotions have a cognitive component which involves beliefs. Emphasising the importance of regarding emotions as identifiable markers in the practice of pastoral care, Doehring (2014, p.595) argues that

> [w]hen caregivers and care seekers collaboratively identify the emotions that trigger and energize these lived theologies and spiritual orienting systems, they can begin to explore the emotional and narrative logic that dynamically connects particular beliefs/values with habitual ways of coping.

In "The Wounded Healer," Nouwen (1977) makes it explicit that pastoral care paradoxically deepens rather than avoids pain, as it seeks to deal creatively with the depth of the human condition in such experiences as doubt, confusion, guilt, alienation and fear. Lyall (2001, p.101) writes: "[t]o offer pastoral care in the light of the cross is to do so in a context in which human vulnerability and brokenness can be expressed, contained and transformed." Despite the agonising struggle that came with having to live with his personal inner wounds, Nouwen (1977) devoted his life to bringing healing to others who were wounded. Dykstra (2005, p.75) suggests that for Nouwen (1977), "counseling becomes the paradoxical, perhaps cruciform art of withdrawing oneself, of making oneself somehow less for the sake of making space for

others, for enabling them to become something more." Just as Christ's broken body became a source of consolation and healing, so the pastoral carer's own innermost wounds, as claimed by Nouwen (1977), may become a means by which others find hope and comfort.

2.3.4 The pastoral carer

The practical application of Osmer's Four Tasks of Practical Theology

Osmer (2008) has analysed the essence, interpretation and practical application of practical theology. I will look at these as applied to pastoral care. He proposes four key questions that can be used to address the pastoral care of an individual, focusing on 'what is happening?', 'why it is happening?', 'what ought to be happening?' and 'how do we move towards making this happen?' To answer these questions, Osmer (2008) provides logical steps from listening, via the prophetic and interpretative stages, to a pragmatic engagement with the issues involved when engaging in pastoral care. It is a symmetrical approach, in that it offers both clinical inclusion of sociological and psychological interpretations, and theological orientation when determining how to give appropriate pastoral care.

1. 'The descriptive-empirical task' – priestly listening
2. 'The interpretive task' – sagely wisdom
3 'The normative task' – prophetic discernment
4. 'The pragmatic task' – servant leadership

2.3.4.1 'The descriptive-empirical task' – priestly listening

Osmer's (2008) descriptive-empirical task asks: "what is going on?" His definition of the descriptive-empirical task starts with a particular kind of attentive listening. In 'priestly listening,' the theme is essentially narrative, as the person being listened to is encouraged to tell his or her life story in a safe and accepting environment. There is a practical necessity to listen in order to glean all the facts of a situation so that the listener can respond from an informed position. In certain circumstances, it is also crucial to remember that the individual approaching for pastoral care may only present one facet of the narrative and there may be others who need to be listened to. However, it is also important to remember limitations of

one's role in that; given the complexity of certain circumstances, even listening, may require professional assistance.

Listening to the voices of the marginalised

Boisen (1946, p.38) is recognised for instigating a turning point in clinical pastoral care when he coined the metaphor of "the living human document" to describe the individual in need as a source of theology. Boisen was influenced by Mead's theory of the social nature of selves (Mead, 1934), believing that it is the experiences, narratives and perceptions that each person has in relationship to others that give insight into one's psyche, values and worldview. Gerkin (1984) adopted Boisen's metaphor that humans are to be read, interpreted and respected and added a further hermeneutical emphasis. Miller-McLemore (2005) critiques, but also develops, Boisen's guiding metaphor and turns towards the metaphor of "the living human web," placing further emphasis on not only listening, but also relationships. The web suggests that context is integrally important to understanding living human documents, in that interpersonal connections in the form of relationships, are essential to understanding one's identity. Miller-McLemore (in Moessner, 1996, pp.21-22) argues that "[t]his lesson - that we must hear the voices of the marginalized from within their own contexts - is one that pastoral theologians have known all along, even when Boisen claimed the validity of his own mental breakdown." Boisen (1971) emphatically believed that his mental illness was, in fact, a religious experience and was convinced that religion had a problem-solving and curative nature.

Listening with love

Osmer emphasises that the whole church community should be involved in priestly listening. He explains (2008, p.35) that "[i]n the New Testament the entire Christian community is portrayed as a holy and royal priesthood (1 Pet. 2:5, 9; Rev. 1:6; 5:10), which is joined to Christ, the one true high priest and sacrifice (Heb. 2:17)." Osmer (2008) outlines the necessity of the entire community being aware that they have a role in pastoral care; all of the community is invited to practice priestly behaviours and is encouraged to confess sins to one another (James 5:16), pray for one another (Eph 6:18) and bear one another's burdens (Gal 6:2) (Osmer, 2008). Tillich (1963), however, cautions against having a mechanistic outlook, especially when considering caring for those who are vulnerable. He encourages a

fundamental desire to understand and help one's fellow humans as a prerequisite, and warns that listening, as an essential part of pastoral care, must not become dilettante psychotherapy, but rather an act of love. An essential quality in a counsellor, as described by Clinebell (Clinebell and McKeever, 2011, p.467), is one's affinity with the troubled person: "[t]o identify with the essential humanness of despairing persons threatens our fragile defences against our despair. … To accept this truth at a deep level requires an inward surrender of subtle feelings of self-idolatry and spiritual superiority." Clinebell explains that to be involved in mutually healing relationships is to shatter "the defensive facade of pseudo-omnipotence" (Clinebell and McKeever, 2011, p.467), otherwise a sense of superiority will prevail, creating an impenetrable icy barrier, which is useless in the practice of pastoral care. Tillich (1963, p.28) describes this attentive element in how one relates to one's fellow humans in a helpful rapport as "listening love" which, he argues, is one of the most vitally important acts fulfilled by individuals offering pastoral care. Tillich (1963, p.28) explains that "listening love" is "one of the decisive characteristics of love that listens sensitively and reacts spontaneously." His definition of "spontaneously" is a natural, empathetic and instantaneous feedback to those circumstances and fellow humans needing aid. Tillich explains that "listening love" does not by necessity have to contain a verbal response, but often the response of presence can effectively emanate love. Listening with love in pastoral care requires that one surrenders efforts to control, manipulate or pre-determine the pathway taken by the individual in responding to her suffering.

Listening and presence

In "The Art of Listening," Pembroke (2002, p.25) explains that in offering pastoral care one should focus more on "sustaining spirituality that communicates presence." Campbell (1981, p.16) concentrates on the "mediation of steadfastness and wholeness" as distinct from competence or insight; this, he insists, depends on "the immediacy of our bodily presence." What pastoral counsellors do, Dittes (1999, p.61) says, is witness: "[t]he counsellor is content to be a witness, not a player," in the client's life; "[t]he counsellor attempts not to do, to save, or to resolve but rather to simply and intensely regard the person who is seeking care." Listening attentively and using carefully-chosen words and wordless gestures are principal features of the 'client-centred therapeutic approach' (Rogers, 1951). Listening non-judgmentally to what the whole individual is trying to communicate leads to what Swinton

(2000, p.10) describes as the "… resurrection of the person." The presence of such a confidant can offer a portal for the client to become aware of God's presence. Osmer supports Lake's (1966, p.11) perspective in that listening is an activity that reflects the loving presence of God in the incarnation: "God has not only spoken through his Son ... he has listened through his Son." As God's love emanates through intentional listening, transformation can occur, and this is often facilitated by the pastoral carer's ability to step back from their own opinions, preconceptions and motives, and rather to simply practice the art of being present with the one who is suffering.

Self-reflexivity in listening

Research on self-reflexivity focuses on attention to affect, which is explained by Gohm and Clore (2000, p.684) as "the extent to which individuals monitor their emotions, value their emotions, and maximize their experience of emotion." As an emotion-processing strategy, attention to affective cues has direct ramifications on coping strategies. Woodward and Pattison (2002) emphasise that those engaging in pastoral conversations need to be particularly attentive to understanding the unique phenomenon which is presented before them before progressing to sensitively chosen words, and this requires self-reflexivity. Woodward and Pattison (2000, p.2) emphasise that an interaction such as this can be "crucial" because it can be "transformative" and can significantly affect the client's quality of life. The quality of listening often depends on the sensitivity and self-awareness of the carer. Doehring (2015) emphasises the importance of self-reflexivity in care and explains that embodied listening is essential to care. She writes:

> Communication is more than words. Our bodies convey a lived theology that may not be fully integrated with what we say we believe and value – our espoused theology. Our tone of voice, facial expressions, and posture all communicate our theology to care seekers. (2015, p.45)

Just as the recollections of individuals who are suffering are often communicated in body language that words fail to reveal, so too are the gestures of the one offering pastoral care. McClintock Fulkerson (2010, p.31) further points towards the creation of a certain 'type' of believer through such communication: "[b]odily communications are at the same time part

of formation." This vulnerability adds an extra dimension to the necessity for particular carefulness, as the carer bears an influence on the client's God image and concept.

Listening and the restoration of identity

When Kalsched (2014, p.3) reflects on the impact of trauma on individuals, he comments that often they feel as if "no-one is listening," they feel as if they are worthless and have no identity. Keck (1978, p.62) describes the necessity of "a critical identity". As one cares, "one must enter into their lives to the point that one begins to feel what they feel, yet without losing one's identity." The theme of identity is important to understand in care contexts, as when an individual's story is changing, their identity is also symbiotically changing. Ashbrook (1995, p.155) asserts that "[i]t is in the telling and the listening, the reflecting and feedback, that we come to know who we are." Furthermore, Guenther (1992, p.149) states that "[s]eparated from our stories, we lose our identity." To truly listen, one must be able to feel the suffering and anguish of one's fellow human and provide a steady, consistent influence amidst the whirlwind of competing narratives. The incarnation as the demonstration of the love of God is the framework for the exercise of pastoral care. Isherwood and Harris, (2014, p.43) explain "[f]eminist theology has encouraged engagement with raw/radical incarnation and the vulnerability and bravery to feel and to touch: to understand Christian theology as a skin-on-skin activity, a face-to-face mutual engagement of ever fuller becoming." Osmer (2008, pp.134-135) suggests that providing an incarnational approach by necessity makes the carer vulnerable, avoids any suggestion of superiority on the part of the caregiver, seeking rather to establish the dignity of the sufferer: "it involves both divine disclosure and the human shaping of God's word." Through the re-integration of parts of oneself which have become a stumbling block to growth, it empowers the individual not just to surrender control but also to take control of their lives through embracing a new story, a story of embodied living. Osmer (2008, p.197) emphasises that "deep change is discontinuous with the past." This, however, requires a sense of powerlessness and a lack of control which can be frightening for the individual who is suffering, hence this requires a listener who is open to not knowing the path ahead but filled with a trust that God is guiding the path.

2.3.4.2 'The interpretive task' – sagely wisdom

Osmer's (2008) interpretive task asks: "why is it going on?" Echoing Boisen (1971), Osmer (2008, p.32) states that practical theology offers an invitation to understand the contemporary practices and lives of "living human documents." To achieve this task, Osmer (2008, p.98) suggests that interpretation requires "sagely wisdom." Osmer (2008, p.98) founds his 'interpretive task' on two threads of scripture based on wisdom literature, namely, "Israel's wisdom tradition" in the Old Testament and on the life of Jesus Christ as "God's hidden wisdom revealed" in the New Testament.

The interpretive guide

Gerkin (1997) supplements this by arguing for an increased emphasis on OT sources other than the Pharisaic and Wisdom traditions, such as the prophetic and priestly heritage for pastoral care. He (1997, pp.24-25) condemns the assumption "that the principal Old Testament ancestors of pastoral care practice were the wise men and women: those who gave moral guidance to individuals." Gerkin's (1997) paradigm of pastoral leadership uses the model of "the interpretive guide," who is chosen by virtue of his or her expert skills and understanding of the terrain, which qualifies their competence to lead the way. As hierarchal structures have and are changing in the postmodern context, Osmer (2008) explains that to understand the issues embedded in the community context, 'the interpretive guide' must draw on theories from the sciences and the arts to aid him or her in comprehending the landscape. To ensure good practice, Osmer (2008, pp.100-103) suggests that "interpretive guides" should assess presuppositions by "a communicative model of rationality." This model first prioritises "argumentation," emphasising the importance of a rational argument to support one's claim; second, "perspectivalism," in that reasoning given is always coming from a unique perspective and has its distinct, though unintended biases; third, "fallibility," as psychological and social theories can be flawed, therefore they should be used humbly and cautiously.

Practising wisdom: *Habitus*

Lartey (2013, p.23) writes, "[t]he idea of theology as practical wisdom is related to notions of habits, a way of thinking that is linked with Aristotelian notions of phronesis (practical good sense)." Osmer (2008, p.84) explains that wise judgement must include "discernment of the

moral ends at stake … through understanding the circumstances rightly, the moral ends of action, and the effective means to achieve these ends." There is, however, a necessity, as Graham points out, to ensure that practical wisdom ensures that moral conformism does not become commonplace in community. She writes (1996, p.208):

> I have argued for a model of Christian practice which inherits and inhabits traditions of practical wisdom that are realized and re-enacted through the purposeful ordering of the community. … such a model of pastoral care is thus a refutation of prescriptive pastoral care which seeks to enforce a moral conformity to absolute norms on behalf of controlling and dominating interests.

Graham (1996, p.7) describes pastoral theology as a "performative discipline" where wisdom includes a focus on right practice or "authentic transformatory action" rather than simply right belief. Through moving away from abstract knowledge, *habitus* moves towards knowledge gained in the community and holistic practical engagement in Christian faith., There is, therefore, a necessity to understand the complex landscapes in which the community resides in order to establish a deeper understanding of why circumstances are arising. Graham (1996) and Browning (2007) further the Aristotelian influence as they both draw on the philosophical contributions of MacIntyre (1981) in his work on 'Virtue Ethics.' Furthermore, Smith (2013) deploys the Aristotelian concept of *habitus* as a necessary component of Christian education in the use of practice to aid in Christian formation. Smith (2013, pp.62-63) links this to his "person-as-lover" paradigm:

> Human persons are intentional creatures whose fundamental way of 'intending' the world is love or desire. This love or desire – which is unconscious or non-cognitive – is always aimed at some vision of the good life, some particular articulation of the kingdom. What primes us to be so oriented – and act accordingly – is a set of habits or dispositions that are formed in us through affective, bodily means, especially bodily practices, routines, or rituals that grab hold of our hearts through our imagination, which is closely linked to our bodily senses.

Smith (2013) emphasises that embodied practices, the awakening of the senses and creative use of the imagination involved must take central stage in the formation of authentic faith. Although the cognitive components of Christian education are, of course, important, practices, rituals and liturgy are crucial to strengthen the mind-body connection.

The wisdom of creative reframing

Osmer (2008, p.84) explains that wise judgement is "determination of the most effective means to achieve these ends in light of the constraints and possibilities of a particular time and place." Innovative methods of pastoral care require imagination and creativity. Louw (2000, p.55) explains that engaging the imagination in pastoral practice through the employment of wisdom is "linked to human creativity." Campbell (in Dykstra, 2005) somewhat creatively uses the image of the wise fool, and Capps (in Dykstra, 2005, p.114) writes, "[a]s shepherds guide and wounded healers empathize, wise fools reframe. Reframing is the very lifeblood of wise-fool ministry." As Campbell (in Dykstra, 2005) points out from 1 Corinthians 3:18, Paul disregards worldly wisdom and elevates the fool instead: "[i]f any among you think they are wise by this world's standards, they should become fools, in order to be really wise." He (2005, p.97) interprets this image of a fool as evoking innocence and simplicity but not naivety, writing:

> The wisdom of such simplicity lies in its power to expose insincerity and self-deception. … It is as though they hold up a mirror in which we can see a reflection of our society's and our own hypocrisy.

Just as Campbell uses the paradox of the juxtaposition of wise and foolish, Louw (2000, p.56) suggests that this concept of the wise fool "unmasks reality with the aid of an apparent contradiction: a crucified and suffering God is the power of our salvation." The reframing of wisdom in pastoral care embraces suffering and is exempt from egotistic endeavours, embodying the humility which is characteristic of God incarnate.

2.3.4.3 'The normative task' – prophetic discernment

Osmer's (2008) "normative task" asks: "what ought to be going on?" It seeks to perceive the will of God for contemporary realities. Pastoral care is a prophetic task that applies to the realms of intrapersonal and interpersonal relationships; it also takes seriously the need for transformation of societal structures that hinder people's growth (Osmer, 2008). He (2008, p.133) explains that the expression "prophetic discernment [is]… the interplay of divine disclosure and human shaping as prophetic. ... The prophetic office is the discernment of God's Word to the covenant people in a particular time and place." Osmer's prophetic

discernment uses three methods to apply theological truths in the present: theological interpretation, ethical reflection and good practice.

Theological interpretation

Osmer (2008, p.135) suggests that the task of prophetic discernment entails "… the task of listening to this Word and interpreting it in ways that address particular social conditions, events, and decisions before congregations today." Gerkin (1997, pp.24-25) has written extensively on the significance of "social factors" in shaping the consciousness of persons, their communities and the world. These factors are an important part of Osmer's (2008, p.139) theological interpretation as they focus "on the interpretation of present episodes, situations, and contexts with theological concepts." Miller-McLemore (in Dykstra, 2005, p.42) outlines the contemporary relevance of this; she asserts that to think about pastoral care and theology from the perspective of feminism "… requires prophetic, transformative challenge to systems of power, authority, and domination that continue to violate, terrorize, and systematically destroy individuals and communities." Although theological interpretation draws upon biblical and systematic theology, and certainly uses biblical concepts, the emphasis is placed on circumstances in the present. Pastoral care must be modelled on Christ's prophetic discernment of God's Word which challenges the ecclesiastical status quo and inspires transformation (Osmer, 2008).

Ethical reflection

Drawing from Ricoeur (1992), Osmer (2008, p.149) suggests that "the identity-shaping ethos of a moral community that is embodied in its practices, narratives, relationships, and models" is a necessity in prophetic discernment. He provides a number of models of prophetic discernment in relation to pastoral care, including Browning's ethic of equal regard (2007, p.378). This ethic, as the words imply, avoids any sense of superiority or paternalism in the care of others, including what he sees as the harmful effects of a pattern of care based on "self-sacrifice" or "self-denial." For Browning, the pattern of equal regard is founded on the commandment to love others as one loves oneself. Osmer (2008, p.149) affirms the importance of "the universal ethical principles that a moral community uses to test its moral practices and vision and to take account of the moral claims of others beyond this community."

Good practice

Osmer (2008, p.153) calls on paradigms of "'good practice', whether past or present, to reform a congregation's present actions." The inspiration of hope is an example of an indispensable element of the prophetic task in pastoral care and is the undergirding theme of the Christian narrative. Moltmann (1993, 2003, 2012) is convinced that the distinctive contribution of the Christian faith is the hope that it engenders in hopeless situations. Hope can, therefore, help persons to view circumstances in terms of their possibilities and potential, recognising that hope need not be inherent in the actual situation, but rather is founded on the nature of the resurrection. Moltmann suggests that there is hope in God's presence, primarily through God's suffering with humanity in Christ, and hope arises in the unseen possibilities inherent in the nature of the resurrected Christ. When reflecting on his work with deeply traumatised individuals, van der Kolk (2002, p.49) suggests that "[i]magining new possibilities, not merely repetitively retelling the tragic past, is the essence of post-traumatic therapy." Osmer (2008, p.161) is adamant that enriching the relationship between psychology and Christianity could be helpful and explains that good practice refers to the "deriving of norms from good practice, by exploring models of such practice in the present and past or by engaging reflexively in transforming practice in the present." Furniss (1994, p.37) suggests that sociologically new possibilities within the social context can help with presenting helpful alternative definitions of people's situations. Osmer (2008, p.153) is convinced that analysing such contemporary examples of "good practice, [can] generate new understandings of God, the Christian life, and social values beyond those provided by the received tradition."

To connect, see new hopeful possibilities and move past barriers in pastoral care, such as feelings of distrust and fear, there needs to be a guard against excessive preoccupation with rigid discipline and moral concerns. These preoccupations threaten individual personhood and undermine efforts to nurture and instil hope. Capps (2001, p.7) discerns the three major allies of hope: "trust, patience, and modesty" which are central to the pastoral task. Doehring (2015, p.111) explains that "[l]ife-giving spiritual practices induce eschatological moments of hope, shifting people out of isolated suffering and shame into compassion for self and others." Capps (1995, p.1) suggests that "[h]olding those who suffer" means giving them

cause to hold on and continue in hope; he coined the phrase "agents of hope" to describe the mission of the pastoral carer. Through operating in hope, the particular narrative of the individual who is suffering can be contextualised within the broader context of the Christian narrative, giving a sense of meaning and purpose to their pain.

2.3.4.4 'The pragmatic task' – servant leadership and taking action

Osmer's (2008) pragmatic task asks: "how might we respond?" In this pragmatic task, he concentrates on the emergence and endorsement of "strategies and actions that are undertaken to influence and shape events towards desired goals" (2008, p.10.) For Osmer (2008, p.178), when Jesus radically reinterprets the Messianic role concerning the Suffering Servant, he identifies an ethic of "mutual care and service" that rejects "hierarchies of power and social status" in favour of unity and co-operation. He argues (2008, p.178) that what is needed in contemporary pastoral care is a "deep change" through transformative leadership. In this way, Osmer (2008, p.191) states, "the Christian community gives visible expression to the self-giving love of Christ, who exercised God's royal rule in the form of a servant."

Power dynamics in pastoral care

Osmer's (2008) three paradigms of alternative leadership have a revolutionary agenda; he looks at the relationship between the various offices in the congregation on a non-hierarchical, more egalitarian basis. Doehring, however, explains that it is by necessity that there is a power dynamic in caregiving relationships. She (2015, p.45) explains that "[e]verything in creation comes into being within relationships, which are infused with power, defined as an interchange of influence involving agential and receptive power." Power is not absent in the exchange between carer and the recipient of care, rather love becomes the mediator of how this power is managed. Graham (1992) suggests that a more egalitarian, culturally sensitive, systemic approach to care could move the focus of care from the individual into the socio-economic and political realm. He (1992, p.9) posits that this model "seeks to reconnect persons and communities with their traditions, while at the same time assisting with the construction of new traditions." Through reconnection to community using the stability of tradition, pastoral care can be part of a transformational dynamic moving from the individualistic to the communal.

Shared Christian praxis in pastoral care

Campbell (1981) encourages the perspective that shared Christian praxis should be defined as harnessing the collective caring potential of God's people for the edification of the community. He (1986, pp.59-60) notes that in pastoral care a "competence gap" has been created between specialist office-holding counsellors and the general membership of the church. While specialist training is important and necessary for pastoral counselling and pastoral psychotherapy, participation in everyday general human caring under the banner of pastoral care is an essential requirement of the entire church community as a shared praxis. Lartey (1996, p.5) suggests that "… love is a thoroughly 'social phenomenon' which brings us into relationship with others and for others." As he explains (1997, p.7), since love is concerned for "the total well-being of the whole person," it seeks to educate and to foster human growth. Pastoral care should be recognised by corporate activity which places the individual who is being offered care at the centre (Osmer, 2008). Loyal observes (2001, p.xvi) that the corporate life of biblical pastoral care has its theological foundation in "a community of faith which finds its identity in the events surrounding the story of Jesus of Nazareth." Gerkin (1997) presents pastoral care as that multidimensional activity around which the life of church community revolves, illuminating the caring potential of the whole scope of ministry. For Lyall (2001), pastoral care in the corporate church in itself has an integrative and bonding capacity for the entire community. Pastoral care is that which co-ordinates the work of ministry.

Identity in community

MacIntyre (1981) asserts that there is a unity to humanity as a whole and is adamant that in order to comprehend one's life, one must understand one's own identity as embedded in and part of interlocking narratives in community. He reasons, "the story of my life is always embedded in the story of those communities from which I derive my identity" (1981, p.221.) Identity is formed through relationships. When overwhelmed by one's present suffering, establishing identity is difficult, therefore embracing the Christian narrative is pregnant with hope and can redirect the suffering individual's life by providing a stable underpinning narrative. Moving to a place of comprehension, meaning and transformative power can occur when the divine narrative becomes intertwined with individuals' lives. Anderson and Foley (1998, p.5) write, "[t]he goal is not just to discover a world or provide an interpretation of the

world that allows us to live in it but rather to discover and interpret a world that allows us to live with ourselves." Purposeful relationships can provide support especially during periods of deep distress; in these periods a deeper understanding of oneself, others and God can occur. Cooper-White (2012, p.26) explains, "as new meanings are constructed in relationship, the burden is shared and God's compassionate presence is experienced." It is through the dynamic of relationships that one comes to know who one is and who God is, and therefore pastoral care must encourage healthy inter-dependence in community as part of one's restoration.

2.3.5 An overview of literature on pastoral care and EDs

There is useful literature available on the religious history of EDs such as Bell (2014), personal testimonies such as Schivener (2012) and Wilkinson (1998), and material directed specifically at mental health professionals such as Cook (2016). Furthermore, Grinenko Baker's (2005) 'Doing Girlfriend Theology: God Talk with Young Women' does briefly allude to EDs however this is focused on the lives of adolescents. This signifies that there is a lack of ED material specifically designed for use in pastoral care which would be suitable for women over the age of eighteen. There are brief sections in pastoral care books and articles that address the subject within the scope of the broader field of mental health but much of this material is dated, sometimes more damaging than useful, and inaccurate when correlated with current ED research. Furthermore, pastoral care is most often defined in ED research articles as the care received through schools, not churches (Robinson and Nicholls, 2015). This further illustrates that there is a gap in the care of those experiencing EDs in church communities. In Christian pastoral care literature, caring for those experiencing EDs is often pitched as directive advice for those involved in youth ministry such as Gerail's (2010), "What Do I Do When Teenagers Struggle with Eating Disorders?" A common example of such advice would be Kielbasa's (2004, p.166) suggestion: "[i]f the young person denies that a problem exists, talk with the parents and share your suspicions and concerns." Although policies and procedures must be adhered to in a church community, and practical advice can be useful, there is a lack of in-depth literature available regarding how to care effectively for those experiencing EDs and, in many cases, a disregard for those over the age of eighteen and still struggling with the disorder. This is further negatively correlated by my findings, as the

majority of the interviewees who experienced EDs and received directive advice in pastoral care found this approach extremely unhelpful.

Pittock (2014) and Evans (2015) contribute to a theological understanding of Ana's creed, available on 'Pro-ana' websites offering advice for those experiencing AN in their quest to not eat, however these areas of socio-cultural influence do not feature in my findings, therefore are not elaborated on in the discussion chapter. In 'The Church and Eating Disorders', Kent (2013) does contribute to an understanding of how the Church's practices of baptism and eucharist, confessing and being accountable, and the doctrine of Christian Perfection relate to EDs. Given that in excess of 75% of the women I interviewed were suspicious of religiosity and do not attend church, the focal point of this thesis has been guided towards understanding the destructiveness of fundamentalist tendencies in pastoral care and subsequently, potential solutions. Furthermore, from the vantage point of body theology and feminist liberation theology, Eisland's (1994) "Disabled God" and Isherwood's (2008) "Fat Jesus", present extremely challenging images to Church communities and open new possibilities to understanding the concept of embodiment. Embodiment is a relational activity, however, as Isherwood and Harris (2014, p.68) explain, "[t]he Church as the body of Christ shares in a very unstable body, a body that calls all knowledge about bodies into question." As shame from body-based comparison combined with self-loathing and a lack of self-compassion led to social isolation for almost all of the interviewees who experienced EDs, the church body should, in theory, offer an iconoclastic alternative. Although there are various theories as to why women are engaging in EDs, there is a notable gap in Christian pastoral care literature in relation to how these women can be heard, understood and helped.

2.3.6 Conclusion

In essence, pastoral care is, and must operate as, a corporate activity for the entire church. Just as pastoral care takes its conventional function as curative, shared Christian praxis in church communities can function as preventative, being a continual source of support and care through fellow members' joys and tribulations. When authentic pastoral care is present in the depths of suffering, empathetically bearing the impact of an individual's traumatic past, while creating a safe space, the rigidity of frozen emotions can thaw, empowerment can be

found, and a long-lost voice can re-emerge. Furthermore, the biblical narrative of the resurrection can restructure distorted concepts of abandonment by a distant God, and an image filled with hope and new life can provide meaning and a secure attachment even in the midst of psychic pain. Drawing from the paradoxes of The Wounded Healer and the Wise Fool, Dykstra (2005, p.4) suggests that pastoral care derives from its "keen attention to life on the boundaries, making pastoral theology's own questionable origins, as well as its frequent identity-confusion, less its burden than its calling and destiny." Boisen (1946) and Nouwen (1977) both understand that pastoral care is a ministry wherein not only the care receiver but also the carer sometimes experiences personally the pain of life on the deserted and often lonely boundaries of an emotionally ostracised existence. The following research methodology section explains how measures have been taken to accurately hear Voice Four in the conversation; that being those who have experienced EDs, carers and those claiming insight into church communities and mental health.

Voice Four: Feminist theology literature review

2.4.1 Introduction

Feminist theologians advocate that the ideological justification of domination and religious exclusivism in traditional Christology has led to the marginalisation of women. The emphasis on the embodied creation in Genesis 2:25 has significant contributions to make in relation to feminist theology. Prior to the Fall, the body symbolises transparency, communion of persons, trust and uninhibited love. Post-Fall, body-shame is the dominant message, particularly for women. De Beauvoir (1952, pp.xvi-xviii) explains "[t]hroughout most of the world, women play the role of the designated other; therefore, they tend to characterise and carry the projections of all that is threatening and undesirable in human existence, including sexuality, sin, and mortality." The roots of patriarchy are evident in the narrative of original sin, as feminists suggest that in the Genesis narrative, without the weakness and deceit of the original woman there would be no need for a redeeming saviour. In contrast, feminist theologians emphasise the theological concept of the *Imago Dei* which declares that men *and* women are created in the image and likeness of God. This theological principle establishes and emphasises the dignity, equality, and mutuality of women and men and has been a lynchpin for feminist claims for equality in the Church and society. An essential element of the feminist redefinition of ecclesiological discourse lies in identifying, deconstructing and essentially reclaiming those aspects of ecclesiology which have become theological means of excluding women from dialogues of ecclesial praxis. These can be seen as the locations of patriarchal power which have been dominating ecclesiological discourse thus far. Using insights from feminist theology and theologians writing on related fields three specific areas will be addressed:

2.4.2 Feminist theological anthropology

2.4.3 Feminist Christology

2.4.4 Feminist eccelsiology

2.4.2 Feminist theological anthropology

Understanding of the body

An essential part of feminist theological anthropology is the area of body theology. Nonetheless, this has been an area which is under-developed and often neglected in traditional forms of theological anthropology. Isherwood and Harris, (2014, p.43) explain that "[t]raditional Christian theology has been at the heart of disconnection by making people aliens in their own skin." By looking at the body as a site of liberation rather than imprisonment, Pattison (2007, p.190) contends that "[p]eople need theologies that help to affirm incarnate worldly experience rather than to escape or deny it." To illustrate, in Jesus' encounters with women He advocated an incarnate, non-dualistic anthropology for women on all levels, (Mk 5:25-34, Mt 9:20-22, Lk 8:43, John 4:4-42, Mt 15:21-28, Mk 7:24-30, Mk 14:3-9, John 12:1-12, Lk 7:36-50, John 8:1-11, John 20:11-18). Isherwood (1998, p.68-69) argues that:

> what is extraordinary is the deeply embodied, erotic nature of many of these encounters between women and Christ… The road to salvation involves not the ditching of our sensuality but the reintegration of our two natures, just as Christ unified his two natures in one person.

Through women's bodies, the flesh needs to find voice and a form of language that has been suppressed in patriarchal Christian theology. Isherwood (2004, p.148) explains: "The flesh made word enables us to find a voice and to make our desires known". As Hebrew anthropology is determinative for a Christian view of the human self as made in the *Imago Dei*, then a strict dualism between body and soul is rejected, but the perspective of the embodied soul allows for a duality of a human being without creating an opposition between body and soul. Isherwood, (2004, p.140) explains,

> We have begun to hear the bodies of women and to place them as word within our religious and theological reflections; we have cautiously and with much trepidation allowed the flesh to show us the divine rather than submitted to the divine moulding of the flesh.

New possibilities for understanding the concept of embodiment are opened through realising the sacredness of flesh, rather than the traditional view of flesh as sinful. Heyward (1982,

p.xix) explains that we must take our human experience seriously: "[w]e are, left alone untouched until we choose to take ourselves - our humanity - more seriously than we have taken our God." Embodiment is a concept that encapsulates the message of the Bible and should not sit in contradistinction to the Bible; on the contrary, it should be rescued from the periphery of Christian teaching and be rightfully placed back at the centre of understanding of revelation and redemption.

The fundamentals of human vulnerability

Care for the vulnerable is at the centre of Israel's covenantal language and Jesus' ministry. Given the patriarchal, androcentric, and ethnocentric leanings of this language however, feminist theologians often deem this somewhat duplicitous. Brock (1988, p.8) claims that "[t]he Christian attitude towards charity is often built on the idea of the superior helping the inferior, which locks paternalism into the relationship." Nonetheless, with a redefinition of the strong helping the weak, the possessor helping the dispossessed, the OT law can be viewed more as a radical form of equality in the context of vulnerability. Vulnerability is the collective human capability to be affected and also affect others; it parallels receptivity, which points to the ability to be helped, challenged, and transformed. It is a capacity that defines the human condition because all humans are vulnerable. A certain level of self-admitted vulnerability is necessary for "personal empowerment," particularly in the space where a "non-coercive divine power" manifests itself (Coakley, 2008). The unique intersection of vulnerable 'non-grasping' and authentic divine power, is power 'made perfect in weakness' and therefore, self-giving can be an intentional act to demonstrate power in vulnerability (Coakley, 2008). Isherwood (1993, p.61) explains that "Jesus' last symbolic act is one of outrageous self-giving and therefore vulnerability." This openness and disposition of self-giving is the opposite of closed-minded defensiveness and, as modelled by Jesus, forms the foundation of vulnerability. Although vulnerability makes suffering, violence and harm possible, it also enables us to fall in love, to find comfort in and receive love from others. Furthermore, although it can limit potential it is much more apt to enable and furthermore points to the possibility of creativity.

Vulnerability, creativity and play.

Vulnerability is akin to openness to that which is unanticipated; invulnerability is more akin to being closed to change and challenge which thereby hinders creativity (Jensen, 2005). Creativity derives from the courage to accept the innate vulnerability in what it is to be human; as that condition of potential from which both the helpful and the harmful emerges. As a practical example of how creativity and innovative thinking can flourish, Isherwood (2001, p.120) suggests that "we should look at the way language is used and dare to remove words from the realms of negativity to those of imaginative creativity. Our language must name our experience not mold it." For some feminist theologians there are particular difficulties when considering the language of God as Father in light of the father/child, male/female power and dominant/submissive imbalance. According to Ruether (1983, p.69), the 'parent model' of God as father confronts us with a neurotic God who wants to keep us as children. Isherwood (2002, p.17) further accentuates this perspective: "indeed to become autonomous and responsible is a great sin, while spiritual infancy is a virtue." The majority of feminist theologians (Ruether, 1993; Heyward, 1982; Isherwood, 2002, for example), believe that parenting in a patriarchal society is a method of enculturating families to adopt the stereotypic male and female roles. However, as Reuther (1993, p.69) explains "[t]he ethical stance of feminism demands that women no longer consider themselves like children, but as independent, autonomous adults." It is without question that all individuals should seek to become independent adults and that the abuse of power is a violation of vulnerability and causes fragmentation from the self, God and others (Shooter, 2016). Alternatively, there is the possibility of viewing childhood vulnerability as a dimension of the Imago Dei and a vantage point for understanding grace in everyday life as well as the connections between vulnerability, play and creativity (Jensen, 2005). Brock (1998, p.36) argues that "[p]lay links self and world. Through playing the heart heals connects and creates. The relational play space itself is the locus of erotic power, as that space between the individual and his or her world." Through vulnerable engagement with the incarnation as a mutual engagement towards flourishing, the ingredients for a mutual/right relationship are experienced through our capacity to play and be creative together.

Erotic Power

Theology is progressive in its definition of power in terms of a reciprocal transaction of influence, as the flow of receptive power receives, and agential power guides. In her concept of a 'Christology of Erotic Power', Brock (1988, p.52) speaks about community and develops a relational Christology which is no longer focused on the person of Jesus:

> Jesus participates centrally in this Community, but he neither brings erotic power into being nor controls it. He is brought into being through it and participates in the cocreation of it … Hence what is truly christological, that is, truly revealing of divine incarnation and salvific power in human life, must reside in connectedness and not in single individuals.

In attempting to abandon the focus on male power embodied in a particular patriarchal understanding of Christ, Brock depersonalises Christology, arguing (1988, p.105) that "[i]n thinking that a single person, a saviour, or even one group can save us, we mistake the crest of a wave for the vast sea churning beneath it." Stemming from Heyward's (1982) thoughts on *dunamis* and erotic connection, this raw energy is most authentically embraced in vulnerable, reciprocated relationships with others. Isherwood (2002, p.127) explains:

> The erotic, transgressive Christ spurs us on to be limitless and without boundary. This requires that we face imaginatively those boundaries erected in our own minds, cultures, religious systems and environments and overcome them through the power of intimate connection.

By accessing the imagination to overcome perceived limitations, this eradicates dualism, moving away from overanalysis to the senses as part of embodied living. Furthermore, as Isherwood (2002, p.55) explains, "[e]ros allows us to feel our deepest passions in all areas of life and reclaim them from the narrow sexual definition used by patriarchy." The power of the incarnation resides in the power of interconnectedness. Brock (2008, p.17) explains

> Heart is our original grace. In exploring the depths of heart we find incarnate in ourselves the divine reality of connection, of love. The grace we find through heart reveals the incarnate graciousness, generosity and love necessary to human life. But the heart's strength lies in its fragility. To be born so open to the presence of other in the world give us the enormous, creative capacity to make life whole.

As one realises that love resides in vulnerability, this interactive process of erotic power can cultivate an authentic sense of intimacy and furthermore promotes a communal embodiment through the ebb and flow of passionate relationships.

The New Materialism

As materialists form insights based on postmodern theories about the connection between language and the body, they presuppose the analyses of how representations are used to establish and thus rationalise power hierarchies. It is necessary then to realise that language does not always reflect reality but rather language has the capacity to mould one's subjective reality. Reflecting on Tertullian, Paul and John, Rivera (2015, p.12) explains "Rather than rejecting flesh on the basis of its association with sin, I seek to revalue the disavowed traits as integral to corporeality—including its links to the material elements, its vulnerability, and changeability." Drawing from Butler (2013), Rivera (2015, p.13) suggests that "affirmative models of performativity" through intentional practices could shape the flesh in transformative ways. Crockett and Robbins (2012, xvi) summarise the new materialism as something that is "neither a crude consumerist materialism nor a reductive atomic materialism, but a materialism that takes seriously the material and physical world in which we live." As Crockett and Robbins (2012, p.110) explain the new materialism "… refuses both hard core reductionism and transcendentalist new age mysticism. This energy is truly Hegelian Geist, and it is fully material, fully immanent in and as us." Following Malabou's (2010, p.xv) "plastic" materialism, affirming materialism in non-reductive ways Blanton et al., (2016, p.2) explain their preference for insurrection as opposed to the resurrection, "We fashion ourselves not as the mythological phoenix rising from the ashes, but as the salamander, served and bruised – insurrection as regeneration."

An insurrectionist theology has much to contribute in its attempts to deconstruct the dualistic structures that direct so many historical theological concepts. Through emphasising the importance of language in formulation an insurrectionist theology, Vahanian (Blanton et al., 2016) is affirming the power to think and to speak an important emphasise in the lives of women who have been disempowered. Drawing from Derrida's concept of deconstruction

she (Blanton et al., 2016, p.144) explains insurrection takes place from within, "within phallogocentric language, within the history of colonial oppression and white supremacy, within capitalism, within the sin of Christianity—without exoticisms". Through such insurrectionist constructions, we can begin to understand how Christianity has been grounded on a dualism of difference and sameness which need to be surmounted, emphasising again the necessity to embrace our innate fragility and vulnerability. It is in this sense, because nothing is to be discarded, that we can envision how as Vahanian, (Blanton et al., 2016, p.169) explains "A theology of insurrection understands the bind and the burden of inheritance". Although insurrection theology emphasises the move on from the restrictive binds of the past, this approach crucially emphasises the need to use one's imagination to construct creative ways of moving forward into a new future of embodied living. In Keller's (Blanton et al., 2016, p.175) critique of the theology of insurrection's rejection of the resurrection she asks, "why not put some insurrection into the resurrection?" By encouraging "the agonism of conflicting interpretations, multiple ethnonarratives, and potential solidarities". Keller (Blanton et al., 2016, p.175) emphasises the necessity for as compatibility between insurrection and resurrection. Similarly, this echoes Moltmann (1993) as he suggests that hope is founded in an authentic theology of the resurrection and can be as materially embodied as a theology of insurrection.

Imago Dei

Interpretations of the *imago Dei* through history have varied, most of these interpretations can be categorised as, substantive (Ramsey, 1950), functional (Niebuhr, 1943) and relational (Barth, 1958). The substantive approach views the image is an inherent capacity most often associated with reason; the functional approach views the *imago Dei* as seen in action, specifically the exercise of rule or dominion; and the relational approach is seen as the *imago Dei* reflecting the relationships which are established and maintained within the Trinity. Herzfeld (2002, p.304), categorises these approaches to divine image-bearing and human nature as "to be, to do, to encounter". Within a social constructivist paradigm, gender is viewed as a form of social relations, as opposed to the more traditional view of a universal 'human nature' that endures throughout history and without social conditioning. Therefore, feminist interpretations, deriving from this paradigm, often suggest that the *imago Dei* is

patriarchally constructed and needs to be renewed in order to create a more inclusive theology. It is therefore advocated that gender is an artifact of human culture, and not a metaphysical category and thus is inexplicable beyond the context of a particular culture and interpretation (Graham, 1995).

Feminist theologians assert that most language that has been used in traditional theology to describe the *imago Dei*, including metaphors such as 'Father' and 'King' are male dominated because they have originated and developed in patriarchal cultures. Wren, (2009, p.4). claims that "the systematic and almost exclusive use of male God-language, in faith in which God is revealed as incarnate in a male human being, gives a distorted vision of God and supports male dominance in church and society". Therefore, feminist critique of male-centred theological anthropology is intertwined with critique of androcentric tradition concerning the nature of God. The question, "Is God male?" has a direct bearing on whether only those who identify as male can be those most perfectly made in his image (Johnson, 1993). Feminist theologians assert that this undermines women's equality with men, as beings who have been made fully in the divine likeness of God. Therefore, a feminist theological anthropology suggests that if women and men were created was to make visible the characteristics of the divine, to fully embody the divine and understand this mystery, inclusive language must be used. As further discussed on p.100 Chopp (1991, p.3) explains, "As Word, God has traditionally been prevented from being represented by woman, while woman has been configured as taboo and placed on the margins of the Word". Since God created both genders equally in God's likeness, it would be deemed most fitting that God should be equally imagined and portrayed as male and female.

Ramsey (1950, p.250) defines a "substantive" understanding of the *imago Dei* as "something within the substantial form of human nature, some faculty or capacity man possesses" that serves to distinguish "man from nature and from other animals". Substantive interpretations of the *imago Dei* are primarily historical however the characteristics which define the image have varied over time, reflecting the primal concerns of each age. Reason has often been considered a strong component of it. Cairns (1973, p.60) explains, "In all the Christian writers up to Aquinas we find the image of God conceived of as man's power of reason" The *imago*

Dei is intertwined with the human intellect by most authors up to the Reformation, given the influence on both the early Church Fathers and the Scholastics of Greek philosophy, in which reason is seen to be the 'most godlike' of all human faculties. Thus, it assumes that reason exists apart from any action that demonstrates it, therefore the reflection of the concrete life of the body in relation to the *imago Dei* is minimised. Middleton (1994, p.11) writes, "the interpretation of the *imago Dei* among theologians almost universally excludes the body from the image, thus entrenching a dualistic reading of the human condition." A dualistic interpretation thereby diminishes the wholeness of being in the image of God and should be rejected as a misinterpretation of what it means to be made in the *imago Dei*. This dualistic attitude does not prioritise the power of the Holy Spirit to change and renew desires, moving towards a more whole reflection of the image and by consequence the intrinsic aesthetic worth of the body as made in the *Imago Dei* is an unruly, evil shell which one must control. When Paul describes the body of the redeemed as "God's temple" (1 Corinthians 3:16) this was not by intent to produce guilt for the bodily sins which is committed but rather an encouragement to reflect the *Imago Dei* as the 'carved' copy of God and further imply the consequential desire to worship the One who designed it.

The functional perspective most often describes the *imago Dei* in human beings as the visible corporeal representative of the bodiless, invisible God. Clines (1968, p.101) suggests that human beings function as representatives in God's exercise of dominion,

> The image is to be understood not so much ontologically as existentially: it comes to expression not in the nature of man so much as in his activity and function. This function is to represent God's lordship to the lower orders of creation. The dominion of man over creation can hardly be excluded from the content of the image itself.

Based on literary and rhetorical analysis of this Genesis 1:1-2:3 text, Von Rad and Marks, (1972, p.60) note the predominantly "royal" distinction of the text. In this "royal interpretation" of the image of God, humans are appointed and authorised by God to serve as His representatives on earth, ruling and administering the created world and its inhabitants

(Von Rad and Marks, 1972, p.60). When interpreted in this manner, the redeemed humanity as Middleton (1994, p.25) writes, "Is both gifted by God with a royal status and dignity and called by God actively to represent his kingdom." Cortez (2010) suggests that this functional interpretation of the *imago Dei* results in a distorted view of humans and the image. He (2010, p.27) writes, "Humans continue to serve as God's representative stewards over creation, but as sinful beings we have twisted this function so that it becomes hierarchical domination and oppression rather than stewardship as a manifestation of God's glory." Although this distortion is often true particularly when considering oppression through patriarchy, in the Old Testament the *imago Dei* is described as having rule over all creation (Genesis 1:26-27). But there is also the sense in the New Testament that although Jesus had royal status and evidently rule over all creation, he persistently refused the popular acclamation of those who tried to make him King (John 6:15). Although Jesus is prepared to rule with authority over a storm, his refusal to intimidate the weak or the outcast further amplifies this paradox which offers an understanding of authority which is best reflected in liberation theologies. The one who is the perfect bearer of the image of God uses his image to liberate to oppressed, he does not abuse it oppressively over other bearers of the image of God. Such an approach is best seen in a performative approach to the functional aspect of the *imago Dei*, this departs from the traditional patriarchal interpretation of rule and dominion and moves towards orientation and action and seeking the image of God in the other. Kamitsuka (2007, p.81) suggests "viewing selfhood performatively deconstructs the notion that to be created in the image of God means having been given some putatively natural femaleness (or maleness); rather femaleness is seen as a performed effect of the discourse." Rather than being helpless subjects of the reflection, the performative perspective encourages reflecting the image of God as a conscious orientation and chosen performativity. Similarly, Jones (2002, p.60) also develops the performativity work of Judith Butler to explain that humans often perform (albeit in many cases unconsciously) "socially constructed scripts of what it means to be a person." These socially constructed performances can be transformative or destructive; therefore, performing love of self and others is of vital importance to reflecting the imago Dei. Ultimately, however Jones (2002, p.61) suggests that "the power to perform [love] is a gift, not an inherent capacity" and to truly reflect this image one must be "driven by the faith-filled desire to embrace with ever increasing conviction and skill 'the way of life abundant'" (Jones, 2002, p.62).

To consider the *imago Dei* in Trinitarian terms suggests that humans are created to be in relationship by one another. However, as Bacon (2016, p.2) explains "At a basic level, the androcentric nature of trinitarian language serves to promote the male as more fully in the image of God and as the archetype of humanity, pushing women to the margins of personhood." Similarly, Johnston (1993) suggests that the doctrine of the Trinity has explicit connotations that the terms for speaking of God are exclusively, literally, and patriarchally used for male designation which thus justifies the dominance of men over women. By reflecting on the Sophia narrative as discussed on p.97, Johnston (1993) draws a feminist interpretation of the Spirit-Sophia in the tradition that is congruent with the experience of women's lives. Johnson advocates for a renewed understanding of each hypostasis in the Trinity by starting the name of the Trinity with Spirit-Sophia, Jesus-Sophia, and Mother-Sophia. This (Johnson, 1993) approach points to new metaphors, symbols, and names for God, which are related to the Trinity, she (1993, p.273) says that deeming dominantly male language as the only language fit to describe God "absolutizes a single set of metaphors and obscures the height and depth and length and breadth of divine mystery". Aspects of language are more fully explained in the following section on p.99 on Feminist Ecclesiology. Nevertheless, although a shift in speech to more inclusive language may cause a temporary change in the manner in which the trinitarian God is viewed and women's place therein, this may not be enough to cause a lasting effect. Bacon (2016, p.15) suggests that "… changes to traditional trinitarian God-talk may be little more than tokenistic and may not achieve what they appear to achieve on the surface." Bacon proposes moving from a focus on the language of the Trinity to a reconsideration of trinitarian logic. Bacon (2016, p.15) suggests that placing a stress on trinitarian 'logic' causes "a reflection on the triune operations rather than with the triune name." Therefore, the aspect of community in the relationships between the Trinity is of particular importance.

In an operational sense, if the Trinity is fundamentally constituted by relationship, then human beings, as ones created in God's image, are also fundamentally relational. Graham (1995, p.355) explains:

> The decisive impact of gender as a form of social relations is suggestive of a model of human nature as profoundly relational, requiring the agency of culture to bring our personhood fully into being. [...] In a recent version of this, the multi-valented and interactive nature of the Divine is reflected in human relationships of mutual and non-coercive affirmation. Authentic human being is thus fully realized – recognized and made concrete – within human communities that respect dynamism and provisionality of personhood.

González (2010) further acknowledges human difference and particularity that are constitutive of personhood while maintaining that human beings are fundamentally relational creatures by our reflection of God's Trinitarian nature. She (2010, p.76) argues for a "justice-infused understanding of the Trinity" that is the model of right relationship: "… humanity is grounded in God's Trinitarian nature as relational and our reflection of this nature through the imago Dei." Moltmann (1991) emphasises that with this relationship a non-hierarchical perichoresis among the three hypostases exists. In order to dispute the understanding of God as monarchical, Moltmann (2015, p.119) emphasises the need to look to perichoretic friendships among the three divine persons as a participatory yet free relationship just as in human relationships. We "do not constantly need to assure ourselves of our friendship, as is generally the case in love. It is enough to know that the friend is there." Similarly, Johnson (1993) also proposes the concept of mutual friendship among the three persons in the Trinity by linking feminist theology with traditional theology. This perichoretic friendship provides community as sense of equality and freedom without any oppression, or subordination. Moltmann (1992, p.308) explains

> The hypostatic Persons of the triune God are seen and contemplated in their eternal perichoresis and their eternal simultaneity. Through their reciprocal relationships they indwell one another, forming their unity through their unique community, no longer through their unilinear movement. Their unity is constituted by their 'togetherness'. Their eternal 'simultaneity' makes them equal in rank, so that even the Father, for whose glory everything in salvation history takes place, is no longer the First, but One among the Others. The original hypostatic differentiations are ended and consummated in the eternal perichoresis, and it is this that is extolled in the trinitarian doxology.

Moltmann's (1991) social Trinity which explains the design of interpenetrating relationships by perichoresis supports feminist theologians' visions and values, on the sacred right of every

person to have a sense of dignity. For Sporre and Botman (2003, p.382), "The dignity of human beings emanates from the network of relationships, from being in community."

2.4.3 Feminist Christology

Feminist Christology and patriarchy

Most feminist theologians view Christological epistemology from a 'bottom-up' perspective, although for the majority this also must be supported by a 'top-down' ontology. Bacon (2009, p.115) explains: "although the priority of God as triune can and must be upheld as the ontological starting point of theology ... at a logical and practical level, theology always begins with experience; from who we are rather than from who God is." When questioning the androcentric logic of Christology and the maleness of Christ, Daly (1993) suggests it would seem illogical for men to want to give up the identity of being like God simply because of their gender. Therefore, Reuther (1988) and Daly both suggest that if Christ is presented as male he cannot represent the redemptive pattern of humanity for females. Johnston, however, offers a contrary perspective, arguing that "[t]he problem is not that Jesus was a man but that more men are not like Jesus" (2002, p.161.) For Fiorenza (1985) it is not an option to reject the Christian Scriptures or to abandon the writings of the Church Fathers or to endeavour to sit outside the tradition itself. Nonetheless, she insists (p.30) that "Biblical revelation and truth are given only in those texts and interpretive models that transcend critically their patriarchal frameworks and allow for a vision of Christian women as historical and theological subjects and actors." When considering the future of feminist Christology, an eschatological understanding is important, in that we are still moving toward the ideal. In Ruether's (1988) understanding, Jesus did not fulfil all expectations of the Messiah; that is yet to come. However, although the kingdom is not yet here, there are moments when the transcendent becomes present as we see glimmers of justice and reconciliation (Isherwood, 2002).

The humanity of Jesus

Feminist theologians (Isherwood, 2002; Heyward, 1982; Brock, 2008; Daly, 1993, for example) emphasise that disembodiment originates from the damaging effects of dualism which is deeply embedded in our tradition. They suggest that this kind of practice has distanced

humanity from itself, others and God, and furthermore has marginalised and oppressed the vulnerable. They declare that this must be rectified through new theologies of embodiment. Isherwood (2002, p.130) explains,

> The radically immanent Christ is the One who increases in the sharing and therefore to some degree does transcend individual parts of the praxis. Through the power of intimate connection, individuals are carried beyond their limitations into a greater whole, yet they remain embodied and connected with themselves and with one another.

Heyward (2010) is convinced that the life of Jesus showed us equality of the sexes through His human interactions with both males and females. To demonstrate this, she embarks on a task which she refers to as; 'imaging Jesus.' Imaging Jesus may also require re-imaging, which often means releasing of tradition. An example of this would be through embracing the fact that Jesus' humanity is all important, thereby the incarnation can be understood as a relational experience. Heyward (in Isherwood and McEwan, 2016, p.52) explains that "[e]mpowerment is a process in which one's sense of personal identity is enlarged to include the quality of one's relationships with others in the world. In this way, being a 'person' means not simply being 'oneself' but being in relationship-to-others." The incarnation is central to Christian belief, yet traditionally this doctrine has not encouraged a positive theology of the body, despite redemption through the body being the key to the biblical narrative and the crux of the divine incarnation.

Incarnation

As Christian theology requires divine-human reconciliation restoring the fracture caused by sin as the precondition for redemption, in which the cross is often alluded to as an apex of sacrifice and suffering. Furthermore, in patriarchal theology the need for reconciliation is premised upon a fall for which Eve (a woman) is seen to be culpable. Feminist critiques argue against such interpretations and deem this to be more akin to patriarchal valorising of suffering. Murphy (2016, in Isherwood and McEwan, p.90) explains "So women suffered from a double burden of guilt and shame first for sharing the fallen human condition, secondly for being born as the weaker half." Feminist theology however, helps individuals to reframe the perception of the salvific process through which the language of redemption can be

redeemed. Feminist theologians most often view the atonement as advocating victimisation and a helpless vulnerability therefore prompting the question that Grey (1989, p.13) asks, "If the central symbol of Christianity contains with it a message that keeps women impaled on the cross, with societal approval, what message of resurrected hope and redemption can it bring?" The value of the patriarchal interpretation of Christ's self-sacrifice and brutal degradation as a necessity for redemption puts the concept of salvation in question. Isherwood (2001, p.28) asks the question, "Is there anything for a saviour, male or not, to save us from?"

Although the concept of being saved from sin is formative in traditional christologies, for feminist theologians there is a desire to turn the focus to humanity's innate goodness as image bearers of God and away from the need for rescue from the sinfulness of one's own humanity. Raphael, (Isherwood & McEwan, 2016, p.202), writes "the belief that one historical man, Jesus, could rescue all women from sin ignores the possibility that human and divine creativity together can co-create and transform the world." Heyward (1982, p.1) explains that the image of Jesus as rescuer or hero must be reconsidered as this further embeds the powerlessness and victimhood of humanity. Alternatively, by embodying a sense of erotic power where one is actively involved in the co-redemptive process there is empowerment. Raphael, (Isherwood & McEwan, 2016, p.200), explains "…feminist criticism insists that too much speculation about salvation has involved not only the repudiation of nature but also the repudiation of the erotic: that energetic engagement with life of the embodied self, where the union of sexuality and spirituality constitutes human well-being or wholeness." Therefore, in feminist thought, redemption becomes more focused on reclaiming an understanding of the innate goodness in the authentic heart of humanity which has been confused by manipulative ideologies and social structures which have warranted the subordination of the vulnerable.

Although it is essential to consider feminist theologians' thoughts on how the crucifixion narrative can be exegeted in a way that validates subordination and disempowerment, Moltmann-Wendall (1991, p.81) suggests there is an issue with the de-politicization of the crucifixion as what disappears is the "violence of the death of Jesus as an act of the brutal

power of the state." Furthermore, she notes that, through nullifying the value of the cross, feminist theologians risk missing a crucial moment in salvation history and moment of identification for all those who have felt abandoned, "the dereliction of Jesus expressed in the cry: why have you forsaken me?" Nevertheless, given the ways in which the crucifixion narrative has been presented in patriarchal theologies, Moltmann-Wendall (1991, p.77) suggests that it's not surprising that for many feminist theologians there is an outright rejection of the cross (Heyward, Brock, Grey, Daly), she comments "the cross as it is often preached has often had fatal consequences for women." Although feminist theologians understandably express difficulty with the atoning sacrifice and the forgiveness of sins, Moltmann-Wendel (1991) advocates that by moving towards a life-giving theology of the cross women's experiences can be honoured, Moltmann-Wendel's (1991) defence of the value of the crucifixion narrative is further developed in the Godforsakenness of the cross, and furthermore the astonishment of the women who meet the resurrected Christ on their way to his tomb. Perhaps, as Moltmann-Wendall (1991, p.91) suggests, feminist theologians could experience, "a sign of salvation that we can erect out of death and nothingness and transplant into new spheres," in the dialectic of the cross and resurrection. While Moltmann-Wendall (1991) and Jones (2009) question the disregard of the cross in many feminist theologies, their emphasis is on the need to reflect upon the horror of the cross as a narrative of identification for those who has suffered immense trauma. Although Feminist theologians depart from a traditional definition of sin, redemption and an other-worldly eschatological vison, their relational emphasis rightly amplifies the need to focus on the innate goodness of humanity and thus brings salvific hope in the present.

Imago Christi

An understanding of the fall and redemption is of vital importance when understanding the *imago Dei*. For Pelagius, the *imago Dei* was unaffected by the fall and Adam's descendants possess the same intellectual and moral capabilities as he did before the fall (Schaff, 2010). At the other end of the spectrum was Luther, who believed the *imago Dei* was obliterated by the fall considering when man sinned he forfeited this original state of holiness, thus losing entirely the image of God. Luther attacked Augustine's view that the image consists of

memory, understanding, and will because in this case he suggested even Satan could be said to exhibit the image of God. Luther understood the image as essentially humanity's response to God by loving and glorifying Him. Neither extremist view interprets correctly what is means for humanity to be made in the *Imago Dei* considering that nowhere does the Old Testament (Genesis 9:6; Deuteronomy. 32:6; Isaiah. 45:11; 54:5; 64:8, Job 10:8-12; Psalm. 139:14-16) indicate that the divine image and likeness are lost and the New Testament (James 3:9; and 1 Corinthians 11:7, Acts 17:25; Revelation 4:11) confirms the image may be marred but it still exist within humans. Reformed theologians however hold that the image includes humanity's rational faculties and their moral conformity to God, and subsequently the image is in a marred and in an impaired state. Although there are differing views on the concept of the fall as it relates to the *imago Dei* the importance is based on how this is interpreted, whether that be as a journey towards wholeness or a sign of depravity.

The New Testament presents two very different perspectives on the *Imago Dei*. Porteous (1962, p.682) describes the New Testament perspective on the image of God as a "sea change" from the Old Testament perspective. Several of these New Testament texts echo the creation language of Genesis 1 in affirming that humans are or have the image of God created within their essence (1 Corinthians 11:7, James. 3:9) while other New Testament texts portray the image of God as being represented in Jesus Christ (2 Corinthians 3:13, Romans 8:29, Colossians 3:10). As the stories of creation, fall, redemption and restoration are epitomised and made accessible through the story of a human being, Jesus Christ, God's chosen means of communication to finite human beings is made manifest, amplifying the fact that humanity is made in His image. When the New Testament refers to the new creation, it is speaking of the restoration of the image (1 Corinthians 15:49) with Christ as the pattern of the redeemed humanity. The principle emphasis in Pauline anthropology is the restoration of the image (2 Corinthians 3:18 Romans 8:29, Ephesians 4:24 and Colossians 3:10) thus regeneration and sanctification serve to renew humanity after the image of Creator. This sense of restoration or redemption from slavery has particular implications for those who have experienced EDs given that, they often describe feeling like a slave or persecuted by the ED. This process to full restoration towards a more whole reflection of image of God thus engenders hope that recovery and ultimately that freedom is possible.

Vulnerability and atonement

As linked to the distorted power dynamic in the patriarchal parent image for God, Brock (2008, p.49) emphasises that we should no longer see Jesus as hero and accuses Christianity of having a wrong view of power: "Christianity is afflicted with a hierarchical view of power that undercuts its understanding of love in its fullest incarnation - that we are all part of one another and co-create each other at the depths of our being." She stresses that it is this issue of power which is integral to the problems with traditional atonement theology and focuses her Christology away from Christ and onto the community. Brock is suggesting that by refusing to see Jesus as the victim it is possible to see Jesus as an image of shared power, and thus the emphasis is on the sharing, rather than a 'once and for all' event in history. So, instead of the hero and victim categorisation, Brock (2008) Heyward (1982) and Isherwood (2004) suggest that Jesus' and our vulnerability is power in striving at just and healing relations. There is resistance to vulnerability for men and women alike which is often prompted by fear; consequently, a desire to control the 'other' emerges. Ruether (2011, p.212) argues that "[t]here is a constant urge to secure life permanently against death, to secure power as control to ward off vulnerability, to ward off difference by subjugating the 'other' to our uniformity." Through an understanding of the fragility of our heart, we realise the divinity of Christ. Isherwood (2002, p.55) explains: "[t]he divinity that we find lies in the heart's fragility; we are vulnerable, and it's in this openness to the world that makes us both vulnerable and redeemers of the world. We are, as Jesus was, broken-hearted healers. The only way to heal both others and ourselves is in, and through, our redeeming vulnerability." Both Brock (2008) and Heyward (1989) believe that it is in this sense of vulnerability that the potential for creative transformation occurs both in oneself and in the lives of others. As *Brock (2008)* emphasises the broken heart of patriarchy, this *compels* us to find this sense of heartfulness, through realising that we have been damaged yet embodied love is in beating in the heart of a *broken-hearted healer*.

The importance of relationship in Christology

One of the central concepts of feminist Christology is relatedness and connection, as Isherwood (2002, p.55) explains: "[o]ur Christology needs to begin in our deepest form of connectedness and in our ability to create and sustain relationships, we have to allow

ourselves to feel." Through an acknowledgement of our interrelatedness and an understanding (and celebration) of our need to work together - both male and female, without gender distinction or hierarchy - the possibility of liberation from the oppressive nature of patriarchal views for both women and men emerges. Despite the relevance of the Trinity in such matters, few feminist theologians have offered in-depth studies with reference to relationship (Bacon, 2009.) In general, feminist theologians are dissatisfied with the androcentric description in language associated with traditional discussions of the Trinity, as, they argue, God is depicted as a coercive, and power-hungry monarch who supports abuse in relationships. Bacon, however, (2009, p.7) describes Coakley as a feminist theologian who strives to "assess the doctrine of the Trinity on the basis of its ability to affirm the key principles and values underpinning a feminist theological method which takes women's experience as its starting point." Challenging Coakley's perspective, Bacon argues that theologically examining the positive aspects of the Trinity can lead to fruitful contemplation concerning subjectivity, self-compassion and difference. According to Bacon (2009, p.196), "God then need not be reimaged in new ways to resist and subvert the reproduction of male dominance in our thinking about God because thinking God as Trinity claims that God already eternally exists in such a way as to challenge and subvert these dynamics." Coakley invites the reader to re-conceive this imagery as linked to desire; for God and of God. She suggests (2008, p.35) that the Holy Spirit is often viewed as the most obscure Person of the Trinity:

> [i]f, then, these traditions of Christian "contemplation" are to be trusted, this rather special form of "vulnerability" is not an invitation to be battered; nor is its silence a silencing. By choosing to "make space" in this way, one "practices" the "presence of God" - the subtle but enabling presence of a God who neither shouts nor forces, let alone "obliterates."

Although the traditional expression of trinitarian faith speaks of Father, Son, and Holy Spirit and appears to give priority to male imagery concerning God, there is also the aspect of the appropriate balance of power in community and authentic relationship. The relationship displayed in the Trinity can be viewed as a display of vulnerability and mutual trust for both the members of the Trinity and those who choose to practice the presence of God.

Sophia

When the Hebrew Bible was translated into Greek, the word "wisdom" became the Greek *Sophia* and is one of the few female images for God in the Bible. Some feminist theologians seeking understandings of Jesus that are empowering rather than debilitating to women, abandon any discussion about Jesus per se, and take up a new perspective such as goddess religion. Mollenkott (1984) suggests that *Sophia* can replace the Virgin Mary as a positive role model for women, whereas others prefer to focus on the characteristic of wisdom in Jesus. Despite the patriarchy of many aspects of the early Church Fathers, many did focus specifically on the wisdom of Jesus. As an example, Clement of Alexandria (see Engelsman, 1987, p.143) claims that Christ "is called wisdom by the prophets… the teacher of all created things, the fellow counsellor of God who foreknows all things; and he who trains and perfects." Instead of *Logos*, Isherwood (1999) turns to *Sophia* as, not so much a metaphysical, but a contextualised embodied symbol of the Divine. With an emphasis on wisdom and truth as found through embodiment, Isherwood (2002, p.104) explains that

> [t]he colonization of *Sophia* (wisdom) into *Logos* (word) by the Christian tradition was a regrettable step. Not only did it deny the divine a female face, but it also made very 'heady' a reality that was embodied. Divine wisdom as understood in the Hebrew Scriptures was active among the people walking in the market place and connecting people with the earth and everyday concerns. She was understood as the divine who led people to wisdom through rooting and grounding in themselves and their cultures."

Johnson (1992) explores each person of the Trinity through the lens of *Sophia*; she (1984, p.438) contends that "[t]he feminist reconstruction of Christology entails an appropriation of the Sophia/Wisdom tradition for Jesus and a corresponding spirituality and re-imagining of Jesus as the Wisdom of God." Keller (1986) notes that if theologians understand wisdom and mutuality better than they did in the past, feminist theologians in their understanding of *Sophia* must be accredited as at least partially responsible.

The crucifixion and trauma

Traditional theologies look to the cross as a place of noble sacrifice, while many feminist theologians have argued the cross is instead a patriarchal valorising of suffering. Jones (2009,

p.85) questions “How can ministers craft sermons that speak to the plight of trauma survivors without retraumatizing them?” Similarly, many feminist theologians have expressed distress regarding the atonement model used by fundamentalist communities which commands the divinely mandated suffering of an innocent victim, deeming this as a nefarious encouragement for domestic abuse victims to accept their abuse as if it were God's will. Althaus-Reid and Isherwood (2007, p.87) explain “By ritualising the suffering and death of Jesus into a salvific act Christian theology has disempowered the oppressed and abused and therefore encouraged the cycle of abuse.” However, Rambo (2010, p.172) claims that healing is possible through “a transformation of the depths themselves.” Furthermore, Rambo (2010, p.162) elucidates, “[i]n the aftermath of a traumatic event, practice and ways of life that people knew before trauma can never be fully recovered and restored as they once were. Instead, forms of life must now emerge with death as a shaping force.” Transforming the darkness into light is possible as the love of God is mediated and cascaded through the witness and care of a community grounded in love. Although Althaus-Reid and Isherwood (2007, p.86) point out the dangers in an atonement model they suggest “[…] the spirituals remind us there is a strong strand of theology formed in slavery that considered only Jesus and not God, could feel the oppression and so bring hope.” The Acts 2:23 affirmation that the death of Jesus by crucifixion happened "with the foreknowledge of God, according to a definite plan" proves difficult for many feminist theologians to endorse, because it fails to reflect the characteristic of a loving God who values empowerment. If, however, the dynamic of the Trinity is understood in the manner that Jesus is God, the giving of the son then becomes a radical act of self-sacrifice and the crucifixion becomes the event which symbolises the ultimate embracing of vulnerability.

Resurrection

The resurrection has critical implications for theologies of gender that base themselves in natural law. The resurrection unravels the necessity of this pattern, for it negates the finality of death but also again emphasises the necessity of embodiment in the gospel story. Stuart (2004, p. 62-63) writes:

> [i]t was not just that God defeated death, but that God did so in human flesh, and this has profound implications for flesh itself. It bursts from the tomb, the same but different: a flesh no longer made for cleaving nor for oblivion. … For a Christian, death does not even threaten the end of bodiliness, but rather becomes a physical experience/encounter with the divine.

By exploring and viewing the meaning of resurrection through a post-traumatic lens, Rambo (2010) suggests that if the Christological story passes too quickly from the crucifixion to the resurrection, it bypasses the opportunity to speak healing to people who have experienced trauma. Rambo (2010, p.144) thus focuses her insights on trauma as linked to this transformative "middle" between crucifixion and resurrection. She (2010, p.144) advocates that it is from this middle that we can reinterpret suffering in innovative ways explaining "If viewed from the middle, redemption is about the capacity to witness to what exceeds death but cannot be identified as life. Redemption finds new expression in the always here, in the persistent witness to what remains." Moltmann (1994) explains that hope in unseen possibilities reflects the creative act of God through the resurrection of Christ. He (1967, 1971, 1975) emphasises that this is not merely a matter of historical reference or a point of reference to future hope, but rather an opportunity for participation in a life-giving force and healing in the here and now. The resurrection is personal for the individual, yet communal for the body; through letting go of the need for individualistic certainty in temporal existence and looking toward a relational embodiment, hope becomes possible. One cannot find identity in isolation; thus, the resurrection hope becomes visible in the collective church community.

2.4.4 Feminist Ecclesiology

A deconstruction of aspects of ecclesiology which encourage patriarchy

Although there have always been alternative traditions of women's leadership and theology, patriarchal models have always dominated. Consequently, women's traditions have often been marginalised, especially through the canonisation processes in which feminists argue that women have been recorded as attendants, but not participants. Fiorenza (1993) scrutinises the ideology of the Roman Empire and insists that its systems of power were

dominant factors in the suppression of women in the formation of the biblical canon. She argues (1993, p.4) that feminist theology must "bring to the fore and make audible again the subjugated voices and suppressed traditions that left traces in ancient writings." Much of the deconstructruction of patriarchy, and indeed construction of feminist theological ideals, is centred around voice and, furthermore, language. The centre of Chopp's (1989) ecclesiology is on the spoken, preached Word. She views 'the Word' as the perfectly open sign which essentially can be understood as empowerment to speak. It is central to ecclesiology that women experience themselves as participating in this process of speaking and interpreting 'the Word,' the main task being the proclamation of "emancipatory transformation" (1989, p.94.) Although the language of traditional Christianity can be an issue of varying viewpoints, Chopp (1989) employs part of the canon of symbols of traditional Christianity such as 'sin' and 'grace', even though she re-defines them as central terminology to her ecclesiology. To illustrate, she defines the *ekklesia,* as a place "which opposes patriarchy, and which envisions new ways of flourishing… in terms of the denunciation of sin and the annunciation of grace" (1993, p.52.) 'The Word' and indeed language, for Chopp, (1989) creates and constitutes the life of the embodied community and is the heart of the church. To illustrate how 'the word' could be used in an empowering manner for women see Appendix 22.

The social symbolic order

Feminist theologians question the function of ecclesiology in preserving a certain social-symbolic order; Watson (2001, p.69) proposes that "[w]e must question the function of ecclesiology as a discourse which describes the church as a vital religious space but does so in a way which supports a particular, predominantly patriarchal social symbolic order." According to Chopp (2002), the community precedes the individual, the individual cannot be perceived as outside of particular social structures, be they oppressive or liberating, and both community and individual are subject to constant change and transformation. For Chopp (2002) 'the Word' can change the social-symbolic order when it is asserted with the objective of transforming its principles and institutions. Christian language was created within the framework of patriarchy and is the major contributor to the social symbolic order. The emancipatory transformation that takes place within the community which is made possible

through the Word of liberation not only enables the community to speak out against sinful structures, but also to announce, to proclaim grace and liberation to the world. Chopp's (1989) concept of "emancipatory transformation" involves, in Frascati-Lochhead's (1998, p.168) Kenosis and Feminist Theology, "not corrections of, or supplements to, the social-symbolic order, but rather a reordering, a 'rending and renewing' of the order itself." Daly (1993) holds an extreme, and, arguably, no longer theological position, rejecting any form of religion, institutionalised or not, and suggests it is a means of creating oppression and male dominance over women. Anderson (1998) criticises Daly for replacing one oppressive social symbolic order with another, suggesting that it is delusional to think that there will be a simplistic end to the present social-symbolic order. Daly's disruption of the patriarchal religious may not be the best way of embodying women in theology. Anderson (1998, p.156) writes: "[a] mere reversal of power cannot confront the mythical configurations of a divine reality, especially patriarchal myths of our desires, loves and fears, which remain part of our personal and corporate histories. Myths are not easily erased, and histories are not wisely forgotten." Therefore, the past needs to be reconfigured from one of oppression, into looking forward into a period of freedom, but, importantly, alongside a wise remembering the suffering of those who have been marginalised, particularly, in this case, the lives of women.

The body of Christ

The Christian church is defined as the body of Christ which is united by Christ as its head and celebrates the diversity of its members (I Cor. 12; Eph.4.) Such body symbolism is of particular importance for a feminist critique of the church. The tradition has often identified women with bodiliness and declared such bodiliness impure and defiling. Feminist theologians (Ruether, 1985; Isherwood, 2008; Brock, 1998) contend that women have been indoctrinated by patriarchal Christianity to comprehend their bodies as corrupting the body of Christ rather than as embodying the body of Christ. Thus, a feminist critique of ecclesiology commences from the assumption that it is women's bodies into which the story of Christ is attributed, and which perform it. A feminist ecclesiology which reclaims Christology as one of its fundamental dimensions has to move beyond the category of gendered concepts that distinguish between a masculine Christ and a feminine Church, as these categories are merely

effective in establishing and maintaining structures which restrict women's participation within the Church to the realm of the non-public and non-political. If a binary view of the male Christ and the female church exists in the mind of the Christian, this must be transformed by claiming that women's presence and representation on both sides of the binary is necessary for the concept of the body of Christ to become real and relevant for women. The Eucharist as a symbol of what Ruether (2001, p.75) views as "clericalism" is perhaps the gravest distortion of what the Church is meant to be and causes a separation between the ministry and mutual interaction with community, especially for women. Ruether (1983, pp.18-19) expresses this principle as follows:

> The critical principle of feminist theology is the promotion of the full humanity of women… Theologically speaking, whatever diminishes or denies the full humanity of women must be presumed not to reflect the divine or an authentic relation to the divine, or to reflect the authentic nature of things, or to be the message or work of an authentic redeemer or a community of redemption.

Patriarchy and Community

When church community has unhealthy power dynamics, hierarchy becomes damaging and oppression and marginalisation of the vulnerable is evident. Keller (1986, p.137) asserts, the "self-structure of separation is a patriarchal artifice." What she calls "... arachnean religion" (1986, p.137) involves the spider's genius of restoring the web that the separative self, determined to be individualistic, has broken. She suggests (1986, p.228) that the wisdom of females in Western history encourages community through "spinning oneness out of many and weaving the one back into the many." Similarly, Chopp (1989) insists that patriarchal communities are webs of sinful, destructive relationships of oppression and the *ekklesia* is the space where these structures of patriarchal oppression and sin can be analysed as well as denounced. All binary structures, according to Ruether's (1985) concept of patriarchal ideology, are essentially modelled on and resemble the male-female division which creates boundaries that deny the building of authentic community. The central task and raison d'être of the Church is to maintain a critical presence in the world. Chopp, (1989, p.85) explains: "[f]or a world that has distorted the richness of difference and particularity into the violence of control and repression and that suffocates the plenitude of desires and dreams, the possibilities of community today must be heard and lived out." If the presence of women in the Church is traditionally positioned as submissive, and heteropatriarchal relationships are

its most fundamental structure, it appears that women's sufferings in religious patriarchy have to be analysed structurally in order to liberate the emancipatory power of the Christian community.

Emancipation and Community

Russell (1993, p.21) furthers this sense of inclusivity through the "table principle." From a feminist liberation theological perspective, Russell (1993) suggests that an authentic Christian community shows hospitality and embraces those marginalised by society, through overcoming the division between margin and centre. Chopp (1989, p.84) takes Barth's concept of the relationship between 'the Word' and the community as her starting point, but as her understanding of 'the Word' differs from Barth's, so does her concept of the community: "[f]eminism's theological reconstruction of Christian community can begin with Barth by asking how, within the words of women, community is created in, with, and through the Word in the reception of the Scriptures and the reality of emancipatory transformation." Rather than viewing women as the ostracised group, Fiorenza (1991) reframes the concept of church by returning to the original interpretation of *ekklesia* and its effect on community and discipleship in the early church. Fiorenza (1991, p.15) explains that "[t]o link *ekklesia* or church with women makes explicit that women are church and have always been church. It asserts that women have shaped biblical religion and have the authority to do so. It insists on the understanding and vision of church as the discipleship of equals." In Chopp's (1989) ecclesiology, grace describes the vision of abundance, right relationships and flourishing, which is anticipated in the life of the *ekklesia* and proclaimed to the world. The praxis of Jesus is one of fundamental openness to those marginalised and excluded in society, which is to be continued by the Church in its praxis of hospitality. Rambo (2010, p.172) claims that healing is possible through "a transformation of the depths themselves." Transforming the darkness into light is possible as the love of God is mediated and cascaded through the witness and care of a community grounded in love. She asserts that this practice is the "work of making love visible at the point where it is most invisible" (2010, p.171.) Lynch (2012, p.561) commends Rambo's work as having the potential of pastoral application however is critical of her "medical, neurological, or physiological understanding of trauma". Lynch (2012, p.561) explains what she believes to be the neglected aspects of Rambo's work "The emotion of the traumatic event is bound into the alternative neurological pathways, and this disintegration

of matter may prevent the victim from building hope in future events, and thus a future. Thus, the victim may become broken, fall into a void, and lose their sense of time passing." Therefore, although Rambo contributes helpfully in many ways to the discussion on trauma the failure to explain the neurological functioning of the brain, the difficulties with language acquisition and subsequent difficulties in integration is deemed to be a significant weakness in Rambo's work (Lynch, 2012).

Women-Church

Fiorenza (1993, p.325) differentiates between two distinctive approaches to the concept of "women-church". Fiorenza (1993) describes women-church as 'synod', which finds more implementation in the emerging feminist liberation theology in a European context and feminist liturgical base communities, as embedded in the methodological alliance between feminist-theology and liberation theology, which is most prominently used by the North American authors. By the very nature of their gender, women are often excluded from obtaining clerical power. Ruether, (1993, p.207) makes the case that:

> [c]lericalism is built upon and presupposes patriarchy. The symbols of clerical power duplicate on the level of ecclesiastical hierarchy the symbols of patriarchal domination of men over women, fathers over children. It is impossible to liberate the Church from patriarchy and retain a clerical definition of the ministry.

Ruether (1993, p.207) does not advocate the inclusion of women into these edifices of clerical power, but rather advocates their transformation, referring to this as the "dismantling of clericalism" and the advocation of a new model of church as "a communion of equals." The term "women-church" or "*ekklesia* of women" birthed by Ruether (1985) suggests that *ekklesia* will be authentic only when women are completely integrated into it. Women-church is not an exclusive term with regard to men, but rather seeks to bring awareness to the reality of women's exclusion from ecclesial practices of decision-making. Fiorenza (1991) understands women-church as the movement of self-identified women and men who affiliate themselves with women's struggles in the context of oppressive power imbalances. From this perspective, the patriarchal church cannot claim to be the unique exemplification of church nor be a dynamic experience of the *ekklesia* (Ruether, 1985.)

Feminist 'base communities' for Reuther (1995) are parallel structures on the edge of the mainstream of the Church which ensure spiritual survival within the patriarchal structures of the church. Ruether (1995, p.10) explains:

> [w]hether or not we have reasonable parish communities where we feel nourished in weekly worship, it seems to me that base communities in which small groups of 8-12 people covenant together for regular prayer, study, worship, discussion, and mutual support are an important base for Christian Life.

Feminist base ecclesial communities provide a valid ecclesiological model for the development of a feminist counterculture which opposes patriarchy and seeks to develop alternative structures, but at the same time does not want to separate entirely from the established church and seeks to make creative use of it to eventually transform it. As Ruether (1985) suggests, the development of the liberation concept of the 'exodus community' as a community on its way from patriarchy to the 'eschatological' goal of a liberated co-humanity of men and women, could be critical to freeing the emancipatory power of the Christian community.

Members of women-church claim that while there have been numerous church councils throughout the history of the Church, none of them can be understood as fully representing the *ekklesia* as the assembly that represents those who are women in the church. The members are committed to issues such as women being free moral agents, especially concerning issues concerning reproductive rights, sexuality and women's health. They are also committed to women being full agents in the life of the Church whose contribution to ministry, justice work and sacramental life is essential for the life of the Church. Reuther (1985) argues that women-church represents a certain reluctance to establish power structures which may potentially be abused. It also enables the practice of more participatory models of organisation. Because of this conscious decision to do without new institutional structures, no one group can claim to represent the women-church movement more than any other. Ruether (1985) describes one of the central features of the women-church movement in terms of it being in critical discussion with the tradition, while also symbiotically seeking innovative, inclusive ways of spiritual expression. Hunt (in May, 1991, p.32) argues:

> [t]he strategy I advise for women-church is to redouble our efforts to be inclusive and, at the same time, to encourage women of diverse racial/ethnic groups to be religious agents out of their own integrity in their own communities. Women-church can listen to and learn from these women, whether or not they are participants in our movement.

Separation and withdrawal from institutionalised Christianity may have to take place as a temporary measure for women to create liberated spaces to find their own voice as agents of theology and develop their own concepts of spirituality. However, as Reuther (in Fiorenza,1996, p. 213) suggests, "we need to find creative ways to bring institutional and free communities into interaction so that they can enliven each other, rather than assuming that they are mutually exclusive options."

Withdrawal from the church

Daly (1993, p.132) refutes the Church's all-empowering potential for women and describes "sisterhood" as "cosmic antichurch"; the decisive denial of patriarchal religion which defines all religion. She writes: "As the victims of a planetary caste system whose very existence has been made invisible to us, women have been divided from each other by pseudo-identification with groupings which are androcentric and male-dominated" (1993, p.132.) Women, therefore, must abandon all religious institutions and even religion itself. She understands this abandonment as not only necessary, but as essentially positive: "it is the bringing forth into the world of New Being, which by its very coming annihilates the credibility of myths contrived to support the structures of alienation" (1993, p.139.) The only way in which women can be redeemed from patriarchy is by entering into the covenant of sisterhood which replaces the oppression and silence imposed on women by patriarchy. As Daly's concept of 'sisterhood' would appear to be more disembodied than, for example, Ruether's (1985) women-church, it seems to bypass the possibility for the transformative presence of women's bodies embodying the body of Christ. Therefore, the concept of 'sisterhood' as a symbol of the post-patriarchal anti-church, would be more aptly categorised as being in the process of de-construction and void of constructive use, especially in the realm of feminist ecclesiology.

2.4.5 Conclusion

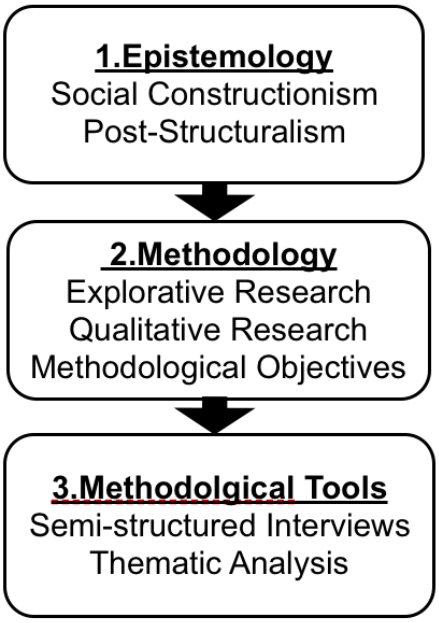
Many traditional Christian teachings have substantiated androcentric theological principles. In response, feminist theologians suggest that this has disempowered and subordinated women and, furthermore, encouraged a false and unethical sense of empowerment for men. It is evident, however, that the dynamic nature of relationships always has an aspect of power and this need not be deemed oppressive in every circumstance, especially when considering one's own power in the context of erotic power. Isherwood (2002, p.60) clarifies this proposition by arguing that this sense of intimacy in relationship, as modelled by Christ, is fundamental to the authentic bonding of a community. "Radical love incarnates the kingdom because intimacy is the deepest faculty of relation […] It is possible to see Jesus' ministry as based on intimacy since he knew people intuitively, insightfully and spontaneously." Aspects of embodiment deriving from body theology are central to feminist theology in which the awakening of the senses to a radical vulnerability and creativity fosters power and inspiration for transformation. As Heyward (1989, p.93) explains, "If we learn to trust our senses, our capacities to touch, taste, smell, hear, see, and thereby know, they can teach us what is good and bad, what is real and what is false, for us in relation to one another and to the earth and cosmos... sensuality is the foundation for our authority." In the context of ecclesiological structures, it is apparent that although Ruether's (1985) opinion does not mean a complete separation from Church, nor the total exclusion of men from women-church's discourses on faith, there are some cases where total withdrawal from the Church may be necessary, albeit temporarily. The goal that women-church communities aim for, as liberated zones in critical dialogue with the institutional church, is that of a liberated co-humanity of both men and women, but "a temporary withdrawal of women" might be necessary for processes of "consciousness-raising" in order to develop a feminist community (Ruether, 2001, p.59). The potential of feminist theological anthropology, Christology and ecclesiology will be further developed in Chapters Five and Six.

Chapter Three: Research methodology

3.1 Introduction

The research methodology will outline the method of data collection and analysis for Voice Five. A number of epistemological and methodological systems have guided and formed the link between the theoretical aspects and practical components of this 'exploratory' project (Denzin and Lincoln, 2005). Mason (2002) deems it vital that these positions are distinctly defined, as they determine and clarify how the data will be gathered and interpreted. The theoretical perspective, methodology, methods and analysis have been shaped by my epistemological view concerning the limits and nature of human knowledge. Crotty (1998) has been used to inform this thesis' research paradigm. Throughout this process, the focus has been on the utilisation of an ethical approach to gather and analyse the narratives of those who were interviewed. The justification for the choices made regarding the research paradigm will be discussed in detail in the following sections as illustrated in figure 3.

Figure 3. Research methodology based on Crotty's Research Paradigm (1998)



3.2 Epistemology

Shenton (2004, p.2) explains that epistemology is the "study of knowledge" and how this is an accurate reflection of reality, the main objective being the identification of the origin of knowledge. Furthermore, Crotty (1998, p.8) asserts that "epistemology is a way of understanding and explaining how we know what we know." Values, commitments and preconceptions contribute to one's understanding of social reality and to what is considered to be knowledge. Crotty (1998, p.2) explains that the justification of a methodological approach "reaches into the assumptions about reality that we bring to our work." Although there is no exclusive epistemological theory appraised as the pre-eminent method of conducting research (Ormston et al., 2014), this research is firmly underpinned by social constructionism (Berger and Luckmann, 1967) and further guided by post-structuralism (Foucault, 1977).

Social constructionism

Gergen (1985, p.266) explains that "[s]ocial constructionism views discourse about the world not as a reflection or map of the world but as an artefact of communal interchange." The term constructivism can be defined similarly to constructionism (McNamee, 2004); however, this latter term is used more in psychological discourse as a mode of perceptual theory linked with Piaget and twentieth-century art. Alternatively, social constructionism, which is incorporated into the epistemology of this thesis, means that society is an objective reality, creatively and actively produced by humans (Berger and Luckmann, 1967). For further indepth information on the manner in which social constructionism forms the foundation of this thesis see Appendix 9.

Post-structuralism

Contemporary post-structuralist research assumes the view that individuals are entangled in a web of social relations. Social constructionist approaches share the post-structuralist premise that language in discursive activities is a social practice which shapes the social world (Burr, 2015). While post-structuralism explores individuals and social relations, it is more concentrated on one's self as a construct and how this is formed through language and gaining a sense of significance within specific dynamics of power (Fiske and Hancock, 2016). Through exploring the narratives of those who have felt oppressed, an understanding of post-

structuralism has helped to frame the power dynamics which were internal and external to the self and provided a more informed position from which to offer recommendations to aid liberation. For further in-depth information on the manner in which post-structuralism influences the structure of this thesis see Appendix 9.

3.3 Research methodology

Crotty (1998, p.3) defines the research methodology as "[t]he strategy, plan of action, process or design lying behind the choice and use of particular methods and linking the choice and use of methods to the desired outcomes." The rationale behind the selection of the methodology adopted is evidently influenced by the ontology, epistemology and theoretical perspective as noted above (Gray, 2013). Crotty (1998) deems the starting point to be the identification of the methodologies and methods utilised in the research project and then to justify their choice. Due to the preparatory nature of this thesis, the methodology for this research has employed an exploratory qualitative approach.

Exploratory research

Gray (2013, p.57) explains that there are four forms of research: "descriptive, explanatory, exploratory and interpretive." The choice for the researcher depends on the background and the purpose of the enquiry. Gray (2013) indicates that exploratory research is particularly appropriate when there is very little existing knowledge about the phenomenon, as is the case with this specific study. Babbie (2015) identifies that social exploratory research is employed when problems are in a preparatory stage; then the research moves on to more descriptive and explanatory stages. Although there is some literature available from a testimonial perspective and specifically focusing on religion and spirituality for those working in mental health, there is a critical lack of literature on pastoral care and EDs. This work is necessarily preparatory, looking at how the Church could respond in order to become part of the solution, rather than part of the problem. The interplay between practical theology and social work is also a notable factor in this exploration and should add to the research depth and the expansion of the body of knowledge in each field. For further information on why an exploratory approach was chosen see Appendix 10.

Qualitative research

Due to the complex and specialist nature of this study, a qualitative method is used in the research paradigm, as it is defined as the task of understanding a human or social phenomenon (Given, 2008). As highlighted there has been little empirical research into the variables of Christian spirituality and religiosity and the impact on EDs, with no evidence currently being reviewed from an NI context. Research into EDs remains a specialist area; therefore, using a qualitative design has aided the task of capturing the phenomenon in depth. It has given the participants a voice to share their experiential knowledge and has subsequently provided insightful real-life perspectives (Ormston et al., 2014). Furthermore, as the literature on the topic of the connection between religion, spirituality and EDs remains underdeveloped, particularly in NI culture, it would be difficult to generate specific and meaningful hypotheses that could be tested by quantitative methods. While describing and analysing the narratives of those experiencing EDs and their carers, qualitative research has accurately gathered a certain quality of psychological experience which has been necessary to accomplish the aims of this thesis (Willig and Stainton-Rogers, 2017). For further information on why a qualitative approach was the best for this doctorate see Appendix 10.

Achievement of methodological objectives

Narratives of women with EDs were explored through semi-structured interviews to help understand and make sense of their EDs in light of religious experience. Carers' narratives were then explored through semi-structured interviews to help further understand the concept of and problems associated with caring for women with EDs. Finally, narratives of those claiming insight into church communities were examined through semi-structured interviews to help understand and make sense of church communities' understanding of, and communication with, those with EDs. The primary data gathered from the three groups was analysed using NVivo and thematic analysis. Secondary data on EDs, fundamentalism, pastoral care and feminist theology was collected as relevant to the overarching research aim detailed on p.11. The primary and secondary data was synthesised. Subsequently, conclusions concerning the effectiveness of the communication between clients with EDs, church members and carers were drawn. The primary and secondary data was analysed and synthesised. Consequently, conclusions concerning church community for clients with EDs were drawn. As a conclusion to the thesis, preparatory recommendations to provide more

effective care for women experiencing EDs were made to provide useful information for church communities and carers.

3.4 Methodological tools

Underpinned by the epistemology and theoretical perspectives outlined earlier, the most appropriate method to gather the data was a semi-structured interview. The participants were recruited using stratified purposive sampling and thematic analysis was used to analyse the data.

Semi-structured interviewing

Mason (2002) identifies three types of qualitative interviews: in-depth, semi-structured or unstructured. She suggests (p.62) that each of these typically involves an "interactional exchange of dialogue," having a relatively informal style, being "thematic, topic-centred, biographical or narrative." Furthermore, she explains (p.62) that the semi-structured interview functions on the premise that, as knowledge is situated and contextual, the purpose "is to ensure that the relevant contexts are brought into [sic] focus so that situated knowledge can be produced." The semi-structured interview technique was chosen to explore this research topic, as it reputably inspires depth in the participant's discourse and provides the opportunity for new concepts to emerge (Dearnley, 2005). In contrast to structured interviews, semi-structured interviews provide the interviewees with more freedom in describing their understanding of their experiences (Willig and Stainton-Rogers, 2017). Therefore, this approach was particularly fitting, as providing a space for the interviewees to have a voice in the conversation has been of utmost importance throughout this research. Further, it has been important to remember that the interviewees' narratives have provided accounts from a certain point of view with particular, often unconscious motives. Therefore, it has been important in this data collection that the voices of both the individual who has experienced an ED and the carers have been heard. As an adaptable research tool, the nature of semi-structured interviewing facilitated the collection of quality material, thereby justifying the use of this tool in this exploratory project. The semi-structured interview questions used are documented in Appendices 11-13. For further information on why semi-structured interviews were deemed the best fit for this doctorate see Appendix 10.

Stratified purposive sampling

Data collection was based on stratified purposive sampling (Sarantakos, 2005), whereby those participating were selected according to their relevant criteria in accordance with the research. A homogenous sample was selected which included participants who have had a similar experience in relation to the methodological objectives (Willig and Stainton-Rodgers, 2017). Denzin and Lincoln (2003, p.202) explain that "many qualitative researchers employ […] purposive and not random sampling methods. They seek out groups, settings and individuals where the processes being studied are most likely to occur." This study used purposive sampling, given that the desire was to specifically explore those who had experienced an ED with an interest in or experience of religion or spirituality, carers with an interest in or experience of religion or spirituality, and those claiming insight into church communities and mental health.

This study also employed a stratified method. As treatment provision and church community differ in rural and urban regions, this was an important stratification, particularly for those who have experienced EDs. Furthermore, as NI is a post-conflict society in which the Christian tradition has been divided by religious orientation, a general geographical stratification of County Antrim and County Londonderry helped to attain both a Roman Catholic and Protestant sample. These stratifications have ensured that data collection was derived from a relatively homogeneous sample, thus facilitating a thorough exploration of the convergences and divergences of experiences of an NI sample.

Sample number and frames

In qualitative research, samples must be large enough to confirm that the majority of the significant perceptions are revealed, but care must also be taken to ensure that the sample does not become too large to the extent that data becomes repetitive and superfluous. Green and Thorogood (2013, p.122) explain that "the experience of most qualitative researchers is that in interview studies little that is 'new' comes out of transcripts after you have analysed 15 or so with a relatively homogenous group of participants." This is supported by Guest, Bunce and Johnson (2006 p.77) who find that, "[f]or most research enterprises, however, in which the aim is to understand common perceptions and

experiences among a group of relatively homogeneous individuals, twelve interviews should suffice."

In this study, there were three groups of participants and forty-three semi-structured interviews were conducted in total. The sampling frames of this selection included: twenty females who were over eighteen and had experienced either AN, BN or both, eight past or present carers of females who had experienced AN, BN or both, and sixteen individuals who claimed insight into churches and mental health in NI. (Pseudonyms and brief descriptions of those claiming insight are in Appendix 14. One of the interviewees who had experienced an ED and also has extensive insight into Christian education was categorised in both groups. Given that those who experienced EDs were of primary interest, this group formed the largest sample size. Data saturation was achieved much more quickly in the group of carers as they were more similar participants, therefore a smaller group was interviewed in this sample. As the sample of those claiming insight into both mental health and church communities was a less homogeneous group, a larger sample was required to accurately establish the divergences and commonalities in the group.

3.5 Ethical issues

Ethical issues: Pre-interview

Ethical approval was obtained from the Research Ethics Committee within the Institute of Theology in Queen's University Belfast (QUB) before the methodology was practically implemented. During the data collection, it was important to consider that the process of listening to the narrative of an interviewee had a moral and ethical element, since the narrative being told contained an element of intimate disclosure (Liamputtong and Ezzy, 2005). Stake (Denzin and Lincoln, 2003, p.154) suggests that the researcher has a certain responsibility, as well as a privilege, in that "qualitative researchers are guests in the private spaces of the world. Their manners should be good and their code of ethics strict." Self-reflexivity was particularly important in the data collection, given the sensitivity of the narratives. However, a growing body of research suggests that qualitative methods pose little threat of distress and that re-telling personal narratives potentially has a therapeutic value (Corbin and Morse, 2003). During the data collection I was distinctly aware that the activity

of telling one's story can be transformative (Liamputtong and Ezzy, 2005) and therapeutic (Gilbert, 2001) but can also be damaging. When considering the existing research which confirms that women with EDs are more predisposed to have had traumatic life experiences, it was imperative that particular sensitivity was applied (Brewerton, 2017). As Olesen (in Denzin and Lincoln, 2005, p.252) points out, "[h]ow to make women's voices heard without exploiting or distorting those voices is a vexatious question." Throughout data collection I was intrinsically aware that the telling and retelling of stories might revive distressing emotions, therefore listening with sensitivity was a crucial part of the process (Polkinghorne, 2005).

Ethical issues: Confidentiality and anonymity

The main ethical element involved in the data collection was safeguarding the anonymity and confidentiality of those who participated. An Information Sheet, Consent Form and list of potential questions were emailed approximately two weeks prior to the interview. In the email exchanges I also offered an option of a telephone conversation to clarify any areas of uncertainty prior to the arrangement of the interview date and time. Furthermore, I was also careful to reassure participants about confidentiality with regard to protecting their identities and addressed any questions they had regarding this before the interview commenced (Miles, Huberman and Saldana, 2013).

Ethical issues: Interview process

There was a level of familiarity with each of the participants, due to email and phone discussions in relation to the research and arrangements of interview time and date before the interview took place. During the period of discussion, before consenting, they were made aware that the research would be published, and of the likely audiences (Denzin and Lincoln, 2005). This period for discussion was allocated to build some rapport with the participants and to ensure they were clear regarding their involvement in the research. Before the interview started, all interviewees were informed once again about the purpose of the research, what the interview would involve and their right to withdraw their involvement in the research at any time. Throughout the interview process, I was aware of and acknowledged the sensitive nature of the content of the interviews and recognised that sometimes what was omitted was equally as important as what was being said (Polkinghorne,

2005). During the interviews I was careful to observe the nuances of body language, the tone of voice and the specific words used by both myself and the interviewee. This was conducive to providing a safe environment for the interviewees but also aided in a more accurate analysis of the interviewees' transcripts.

Those participating in the interviews were informed of their right to stop the interview at any time, and a list of national mental health organisations and helplines was present at each interview in case any participant felt the need to seek counselling or support following the interview. At the close of the interview, the interviewees were asked if there was anything else they thought was important to contribute to this area of research. When the interview was concluded, there was a debriefing, which involved the interviewee being asked how they were feeling about what they had shared and were thanked for their involvement in the study. The consent form and information sheet can be found in Appendices 15-16.

Ethical issues: Researcher bias

When considering interviewer bias in a qualitative inquiry, Ogden (in Given, 2008, p.61) writes that it is imperative "for researchers to be aware of their values and predispositions and to acknowledge them as inseparable from the research process." Views concerning researcher bias are widespread and often considered to be caused by a lack of objectivity, deemed an ethical issue and caused by a lack self-reflexivity (Roulston and Shelton, 2015). Strategies for managing subjectivity with integrity was important in this study because subjectivity in social research is often associated with bias, which is viewed as a definitive risk to the validity of a study (Roulston and Shelton, 2015). A failure to account for and recognise subjectivities can impact observations and the manner in which narratives are heard (Gall, Gall and Borg, 2003). In light of the fact that choice of data selection is the researcher's responsibility, and this can be open to interpretation, it has also been necessary to be aware of confirmation bias, which manifests when researchers choose to interpret data in a manner supporting a pre-existing belief (Nickerson, 1998). When approaching the analysis, I was aware that there are different manners in which voices could be misused, including the use of interviewees' perceptions to reflect biased opinions. Fine (in Gitlin, 2014) develops this thought in the discussion of ventriloquism in research, where researchers put words in the mouths of participants and

speak for them by using extracts which underpin their own values. Further information outlining my personal research bias can be found in Appendix 17.

Ethical issues: Storage of data

All participants involved in the research read the Information Form and signed a Consent Form. Data from semi-structured interviews was collected using a voice recording device and was immediately transferred to a secure, password-protected file on a password-protected laptop and deleted from the voice recording device. All study files, including audio-recordings and transcripts, were stored under passcode in a manner conforming with the Data Protection (Amendment) Act 2003 (Government of Ireland, 2003) in alignment with QUB regulations.

3.6 Thematic analysis

The data was analysed thematically within a social constructionist (Berger and Luckmann, 1967) and post-structuralist epistemology. Thematic analysis is widely used in qualitative studies and seen as a foundational method of qualitative analysis (Braun and Clarke, 2006). The aim of this data analysis is to develop an exploratory understanding of the perceptions of women experiencing EDs concerning the disorder, their religion and spirituality, and their perception of rehabilitation, through the emergence of key themes. Other forms of qualitative analysis, including discourse analysis and narrative analysis, were considered during the development of the research design; however, due to the exploratory nature of this thesis, thematic analysis was employed. Thematic analysis has been a particularly fitting choice of data analysis for this thesis as Boyatzis (1998) confirms that this method can be used to construct meanings while also producing explorable observations.

Method of analysis

A coding structure was designed, and the data coded to anticipate emergent themes using NVivo V.10 software (Bazeley and Jackson, 2013). The themes and issues addressed in the interviews have been linked together under a category system which has focused on being synthesised with existing research (Burnard, 1991). In analysing the data patterns, differences, themes and sequences were initially identified. Collected data was then coded, conceptually organised, interrelated, analysed and evaluated. Methodological insights from

Braun and Clarke (2006) and Burnard (1991) were used during open, focused and theoretical coding.

Three stages of coding

a. Open coding

During this stage, verbatim transcripts of semi-structured interviews were read thoroughly and code words were used for general themes within the transcripts to facilitate the process of immersion (Willig and Stainton-Rogers, 2017). Irwin (2013) indicates that the process of immersion is used in an effort to become more thoroughly acquainted with the perceptive worldview of the interviewee. During this phase of open coding the transcripts were read in depth, while certain words and phrases were assigned a provisional code which, by necessity, was a close representation of the data, rather than representing any pre-existing concepts. Braun and Clarke (2006, p.35) suggest that, in generating these initial codes, data should also be collated as relevant to each code in "a systematic fashion across the entire data set." Constant comparison techniques were used to derive codes and then themes while also ensuring that the repeated codes were authentically fitting the data (Bazeley, 2013). This process produced numerous codes that needed to be synthesised. To ensure the utmost research validity during this stage of open coding, I referred to the initial recordings to stay as close as possible to original contexts and meanings (Burnard, 1991).

b. Focused coding

The second coding phase involved using the most notable or repetitious initial codes to recode the transcripts (Braun and Clarke, 2006). Transcripts were repeatedly re-read, and as many thematic categories as necessary were formulated to account for all aspects of the content in an effort to exclude dross. Willig and Stainton-Rogers (2017) ascribe the term 'dross' to issues which are not relevant to the research topic and to denote the superfluous information in an interview. Constant comparison techniques were used again to make certain that the codes assigned were grounded in the data and not in my own or literature-based pre-existing concepts (Bazeley and Jackson, 2013). Codes that were not an appropriate representation of the data were modified or removed. Transcripts were coded according to a topic which became a child node, then, according to common emergent themes, these topics were sub-grouped under parent nodes (Bazeley and Jackson, 2013). Through the

process of copying child nodes into new parent nodes, themes began to become apparent (Siccama and Penna, 2008). Throughout this process, the child nodes and parent nodes were worked through repetitiously to ensure the utmost validity (Braun and Clarke, 2006). The parent nodes then began to crystallise meanings in the data as codes were collected to establish themes (Bazeley and Jackson, 2013).

c. Theoretical coding

The final coding phase involved the creation of theoretical codes that brought together the child nodes, parent nodes and categories into main themes and sub-themes. As the themes were further defined and named, there was ongoing analysis to refine the specifics of each theme to further ensure the validity behind the overall story the analysis revealed. During this period, I selected vivid and compelling extracts and examples which illustrated the main themes, then synthesised these with the existing literature to produce an accurate report of the analysis (Braun and Clarke, 2006).

3.7 The limitations of my research

While acknowledging that there can be no single correct interpretation of the data underlying this thesis, this does not preclude evaluation of quality and rigour. Validity in qualitative research is premised on a declaration of epistemological and methodological assumptions as providing means for evaluation (Silverman, 2016), all of which I have sought to provide. The triangulation of the data with existing literature has been vitally important in proving the credibility of my findings; as Guest, McQueen and Narney (2011, p.101) suggest, "if analysed properly, convergent data from different methods and sources validate findings." Furthermore, Guest, McQueen and Narney (p.101) suggest that "using verbatim quotes increases the validity of findings by directly connecting the researcher's interpretations with what participants actually said"; I have included verbatim quotes as evidence in the following section which presents the findings. Furthermore, despite the limitations acknowledged above, I have endeavoured to be rigorous, accurate, professional and thorough in capturing the multi-facetedness of ED identity constructions. It is widely recognised that considerations of research quality, particularly in exploratory qualitative research, are important. However, as this methodology explains, and as Oakley (2000) notes, the distinguishing mark of all 'good' research is the awareness and acknowledgement of potential error. Therefore, what flows

from this methodology and the awareness of possible biases, is the necessity to establish procedures within which data collection and analysis will minimise the effect that such errors might have on the outcome of the findings and synthesis of this research.

An inherent aspect of the use of qualitative research methods which explicitly calls reliability into question, is the small sampling when compared to quantitative methods. Accordingly, I ensured that the sampling frame exceeded the number of interviewees recommended to give a consistent representation of the population sample. Mayring (2000), explains that an exploratory qualitative approach does not imply that the research process is not controlled or does not follow well-grounded rules. Considering these factors which contribute to the critique that exploratory research lacks scholarly rigour (Gioia, Corley and Hamilton, 2013), it is essential to establish that context, relevance and interpretation of results will be important quality criteria to apply in this research. Although there are limitations to this research, I have attempted to be as 'objective' about the 'subjective' as possible and declared my personal interviewer bias. Although these narratives are simply representations of reality by three groups of individuals, the themes that have emerged will potentially inform service provision and help to improve the quality of care for those experiencing EDs. Understanding these connections and differences has been vitally important in the construction of the recommendations of this thesis in Chapter Six.

3.8 Conclusion: The relationship between the qualitative research methodology and Voice Four

The core themes that have emerged from the research methodology through the method of semi-structured interviewing will be presented in the following section. These themes were derived from the interviews with the women who experienced EDs, carers of women who experienced EDs and those claiming insight into both EDs and church communities (this group will be referred to as 'those claiming insight'). There will also be references to areas that are unique to a small minority. The nuances and significant differences between the three groups will appear under seven broad core themes. Two further subsidiary themes will also be presented, and relevant findings recorded. To accurately present a thematic analysis of the original findings, this section will not introduce relevant theory or literature; however,

relevant theory and literature will be integrated following these findings and will be presented in Chapters Four and Five.

Chapter Four: Voice Five – The research findings

4.1 Introduction

The critical conversation will be further developed in this chapter as the voices of women who have experienced EDs, carers and those claiming insight into church communities and mental health will be heard.

4.2.1 Core themes

The core themes have emerged as being universally relevant, in differing measures, to the interviewees who experienced EDs, carers of women who experienced EDs and those claiming insight into church communities. Within this overall classification, the core themes are not mutually exclusive. Instead, the boundaries between them are permeable and, in some cases, overlap. One aim of this section is to convey the interrelatedness of the themes emerging from all three groups of interviewees. The detail documented under each theme will also seek to portray the idiosyncrasies and nuances of the unique experience of each group. The themes will be described and explained in relation to the findings of each group and interlinked as similar or distinct, where relevant. The three groups will also be contrasted and compared with the frequency of the references to each core theme. Related parent nodes (being a methodological term used during thematical analysis will structure and categorise the core themes and subsidiary themes as below. These will function as a series of subheadings under the general themes, which will aid in producing clarity and will illustrate the formation of these themes. All names presented in these findings are fictitious.

The seven core themes are:

1. Control
2. Shame and guilt
3. Identity and voice
4. Dualism and disconnection
5. Emotional distress
6. Isolation
7. Compassion

The two subsidiary themes are:

1. Views on the church as supportive to recovery
2. Views on statutory care as supportive to recovery

4.2.1 The core themes

4.2.1.Control

Oppression

All groups unanimously note control as the most relevant theme. The findings suggest two general themes integral to control: first the ED represents a dominating entity in itself, and second, the ED is used as a mechanism to control emotions. Glenda explains, "I just felt like I had no control of anything in my life, and that was the only thing I had control of." Almost all the interviews exposed the distress experienced in what seems like a battle to win control of the ED. Karen recalls her request for help, "I don't know what to do. I feel like this [sic], I so want to control it and I can't control it, I'm trying to control everything else, but this controls me." The majority of those claiming insight understand that the ED is an adaptation used to create the illusion of being in control. They also agree that the core cognition perpetuating the need to control centres around feelings of helplessness. The consensus of almost all the women who experienced EDs is that the lack of control leads to internal oppression and a sense of being imprisoned in one's own body. As Carole illustrates, the ED brings about feelings of "desperation, of being absolutely controlled by this thing that dominated every waking moment and even my sleeping moments." Approximately three-quarters of carers appear to understand the torment of experiencing an ED. As a carer, Dan illustrates this: "anyone who is a victim of anorexia is not fully alive; they're enslaved by an illness which is tyrannical and cruel; they are bound helplessly."

There is particular emphasis on the regulation of food and exercise to control emotions for all of the women who experience EDs. Approximately two-thirds of them suggest that the obsession concerning food and exercise is driven by the need to control. Carole recalls her experience:

> I would say it's a cycle, an obsessive cycle that feeds on itself again of control, how many calories have I burned? How many calories have I consumed? How many calories have I burned? How many calories can I consume? How are my trousers fitting? Compare with this girl, that girl and the other girl.

Comparison of others' physical features also appears to be linked to manifestations of controlling behaviour in approximately two-thirds of those who experienced EDs. Heightened sensitivity to comparison and subsequent feelings of low self-esteem are prevalent in the majority of the women. A further increase in levels of sensitivity is present in those who referred to traumatic incidences in their lives.

The observation of specific and self-imposed 'rules' is a constant feature in the narratives of carers and those who experienced an ED. Limiting food intake, ensuring increased levels of exercise and drinking copious amounts of water was referred to by almost all of those who experienced EDs. Water is often used to control hunger, and in many cases, this is also used to control the scales before being weighed. Lucy comments, "I was drinking six litres of water in the space of an hour before I was weighed." Those who experienced EDs agree the strict rules and preoccupation with food decreases distressing thoughts perpetuated by strong emotions. Approximately half of those who experienced EDs commented on a curious increase in painful thoughts during recovery. Ruth explains, "so then when you started to gain weight and started to recover, oh I have to feel these things, I have to deal with these things." Not knowing how to manage distressing emotions and thoughts is referenced as unbearable at stages of recovery by approximately half of those who experienced EDs.

Family influences

Through almost all the interviews with carers, the distress and helplessness regarding their inability to control their loved one's behaviour is palpable. Exasperation and weariness are constant themes, often appearing alongside anger. Controlling behaviour by parents has emerged as integral to the theme of control. In the majority of cases, as the desire to help their loved one increases, parental control often increases, which appears to have a significantly unhelpful effect. The findings suggest that impatience from parents often adds more pressure which, in turn, further exasperates and disappoints the carers and those experiencing the EDs when subsequent relapses occur.

The desire to please others, especially parents, appears within approximately two-thirds of the interviews with those who experienced EDs. Caroline reflects on her daughter's fear of disappointing her: "[s]he has said before 'I don't want to let you down'." Almost all of the interviewees who experienced EDs described their ED as a way to deal with their emotions while avoiding putting any extra stress on anyone else. Jennifer explains, "it was all a relief like it wasn't visible, and it wasn't emotionally taxing on anyone else but me." Childhood failure appears to be linked to a relentless desire to achieve success in a way which is pleasing to parents or other significant caregivers.

Childhood and adolescent trauma features in approximately two-thirds of the interviews with those who experienced EDs. Abuse was common in verbal and sexual forms; bullying in school also emerged frequently. Almost all of those who mention their experiences of abuse also speak of their parents' inability to comfort them during this period. For all of those who talked about this experience, this was interpreted as rejection by their parents and they all recalled their consequent feelings of shame. Jennifer describes her family experience: "I had no outlet for the trauma, I wasn't allowed to cry, shout or scream or do anything out of order at the time. That's how I learned how to cope. It was like the only way I could cope and stop myself from becoming more destructive I suppose." For all of those who experienced an ED there is an abject fear of loss of control; the loss of control often culminates in anger and an unbearable sense of despair.

Power and church

Half of those claiming insight voice an awareness of power regimes which may be functioning visibly and invisibly in church communities. There is a recognition for over half of these interviewees that the church needs to change its focus to better care for those who are struggling with mental health issues in general. When considering what the church desires to be, Charles explains, "I think it has a hierarchal structure, I think the irony is that it's a bit like an iron log bureaucracy." When returning more specifically to EDs, approximately half of those claiming insight imply that the rigid structure of some churches parallels the rigidity experienced by those with EDs. Approximately three-quarters of all those interviewed mentions the imbalance of power in relationship to gender in churches. A small minority refer

to the imbalance in a positive manner. Approximately a third of all of those interviewed suggest that the gender bias evidenced in churches is a difficulty in pastoral care for women experiencing EDs. Recalling her personal experience, Carole explains the implications of power hierarchies in church:

> for those who have power for example in the church, if they are men, if I have an ED, I'm certainly not going to disclose to the powerful figure that I am weak; that I am needy in any way. I won't disclose that to anybody who has power because it's just too dangerous; it's too risky.

Approximately a third of those claiming insight assert that a sense of oppression around sexism in churches is related to a wider issue in society as a whole. David explains, "I think they can reinforce the extra authority by adding religion to them [sic]." Religious authority being misused to manipulate was a concern for approximately a third of those claiming insight, particularly in the realm of mental health. Approximately a third of those claiming insight refer to power and boundaries as a necessary part of church hierarchy and structure, while nonetheless arguing that this should not be oppressive.

Two-thirds of those claiming insight believe that knowledge of God's sovereignty should prove a comfort to those with EDs. However, those who experienced EDs offer mixed views on the perspective of God being in control, with about a third finding this, as Denise suggests, "robbing of agency" and as Ruth claims, when one adopts the position of God being in control, "the locus of control is external." Louise furthers this discussion by moving the focus to the church leaders, saying "[i]t's the whole idea they take the power from you and give you information as you need it." Approximately half of those who experienced EDs were suspicious of those who are very religious and suggest that some church leaders and members try to control and manipulate those who are vulnerable. For approximately half of those who experienced EDs, there is a notable anger in their tone and a sense of hurt when speaking of religion, church and God, in contrast to other parts of the transcript. Having experience of an ED, Roberta states:

> I'm anti-religious really, 'cause I think that modern day religion brings so many aspects of social control, I think it very definitely for people with EDs it passes

> over the ability to take responsibility for oneself, 'cause you pass your healing or that you're sick onto the fact that it's God's will.

In contrast, almost a third of those who experienced EDs found comfort in knowing that God is in control and around a quarter of those who experienced EDs refer to, as Sarah describes, "God's plan" for their lives. One third contend that the thought of God being in control is irrelevant and not something that is useful in their lives, whereas two-thirds of the carers emphasise the comfort they find in knowing that God is in control. There appears to be confusion regarding the interpretation of God's sovereignty, particularly for those experiencing EDs, therefore this would suggest confusion as to how this divine attribute is presented in church communities.

4.2.2 Shame and Guilt

Shame and pastoral care

All groups agree that shame, feelings of worthlessness and a poor self-image are thematically interlinked. Three-quarters of all of those interviewed suggest that shame and guilt are interchangeable and both cause difficulties in social interactions. Being labelled as having a mental health issue is often linked to shame and consequential stigma for the majority of those who experienced EDs. Claiming insight, Samantha reflects on how she believes stigma could be addressed: "it's not them and us; we're all part of this continuum." Ironically, the necessity to label and have a diagnosis for, in particular, their mental health issues appears as a significant factor for over half of those who experienced EDs. Approximately three-quarters of those claiming insight consider guilt and shame as a dominant factor in EDs; furthermore, approximately a third recognises that shame is often misinterpreted when interlinked with religious views. David explains, "there's a huge potential for those feelings to be reinforced by religion." There is a recognition from those claiming insight that religion can exacerbate neurotic emotions, including fear, guilt and shame. There is also, however, an awareness that there are aspects of religion which can liberate from feelings of shame and guilt. Approximately half of those claiming insight use an illustration of the atonement of Christ when considering issues of shame and guilt. However, more than half of those claiming insight suggest that a call to repentance may not be the most helpful approach to those who

are recovering from an ED. Carole explains, "[t]o confront sin, to call for repentance, to demand change for somebody with an ED, I think that only makes it worse." Two-thirds suggest that demanding approaches regarding repentance in pastoral care is never helpful, as this could be an abuse of the vulnerability of those who are experiencing EDs. When further combined with pre-existing perfectionist tendencies, as recognised in almost all of those who experience EDs, the failure to attain certain standards can cause distress and subsequent self-loathing. Approximately half of those claiming insight warn that approaches in pastoral care, wherein 'directive advice' is given, could cause a reinforcement of problematic behaviours in those with EDs.

Guilt and pastoral care

Guilt and consequent punishment are also common issues for approximately half of those who experienced EDs. Elizabeth comments, "[y]eah, I definitely did feel a guilt, it was like, you reap what you sow, isn't that what it says? And it was like because I did that it was like that's God punishing me and I did feel that's God punishing me. You know for not eating." Approximately half of the interviewees who experienced EDs suggest that religion increases feelings of guilt. Feelings of being a failure and letting people down are consistent among all those who have experienced EDs. Diana explains, "[m]y relationship with God is constant apologising." Approximately half of those claiming insight suggest a need for sensitivity when using religious language, as inappropriate use could further compound feelings of false guilt. Samuel explains: "they already feel a lot of that [guilt] without having to be told this is sin, 'it's sin that you're not eating enough.'" There is a hesitancy in approximately half of those claiming insight to speak of sin and guilt in pastoral care circumstances with those with EDs. Alternatively, about a quarter of those claiming insight deem religious language such as sin and repentance as essential. Harvey suggests the employment of words such as these are "vital … without them there is no future." Approximately three-quarters of those claiming insight see a need for particular care and sensitivity when dealing with the issue of guilt in those who have experienced EDs, while approximately half of those claiming insight comment on the unfounded, anxiety-based shame which is often present in those experiencing EDs. Graham explains, "[t]hen there are people who are struggling with neurotic guilt where they can't shake off a sense of having done wrong in their life." Three-quarters of those claiming

insight recommend that in such cases of neurotic guilt, a safe environment must be cultivated, and time invested as the individual unravels her story. In more complicated cases, almost all of those claiming insight propound that referral to ED specialists is imperative.

Approximately two-thirds of all groups use guilt and shame interchangeably and without distinction in the definition. The shame is associated with rejection for approximately two-thirds of those who experienced EDs. Lucy explains that "[i]t was self-rejection and whenever you reject yourself you interpret everything as a rejection, so everything anybody does, you interpret it as a rejection." For almost all of those who experienced EDs, a sense of rejection often accompanies comparison to their peers and mild paranoia, especially regarding body size and food consumption. Approximately half of those who experienced EDs suggest that a significant part of their recovery is learning to become more self-compassionate. Aoife illustrates, "I think one of the things I'm doing differently is not beating myself up when I do veer off."

Poor self-image

Low self-esteem and feelings of worthlessness feature in all the interviews of women who experienced EDs. Denise explains how she would have described herself at a stage when her ED was most intense as: "[d]efinitely useless, the obvious fat, waste of space, stupid comes up a lot." A sense of worthlessness and feelings of being stupid were the most commonly commented on by those with EDs. Louise explains the sense of inferiority, which is common to most of those who experienced EDs: "I was scum, I mean it started off because I didn't feel as good as anybody else." Joy explains that these "feelings of not being good enough" are often linked to avoidance behaviour and attachment difficulties. For almost all who experienced EDs, subservience and the inability to find one's voice during the most intense stages of the ED is connected to a poor self-image. Diana reports that "[t]he first word that always comes to my head is pathetic, absolutely pathetic, I'm a complete pushover, everybody walks all over me, and I can't stand up for myself." Jennifer explains:

> I always felt subservient to everybody, so like everybody was important, and I wasn't important and had a reason to be important apart from me. So everybody would like, the people who were important if they felt like they weren't important, it was my duty to help them feel important and that was

> where I got any satisfaction from so I just had a generic zero stamped on my head, and everybody else was a ten.

Approximately a third of those claiming insight suggest that feelings of worthlessness are a cause of the suppression of emotions and are common in women experiencing EDs as they cannot conceptualise why anyone would want to listen to them. Anne-Marie expresses, "[t]he secrecy, the silence, the pain, the shame, the inability to share, the inability 'cause it's full of self-loathing, huge self-loathing." Almost all of the carers explain their acceptance of low self-esteem in their loved one, but they emphasise their difficulty in comprehending why this is the case, given their apparent and inherent capabilities. In a state of disbelief, Dan recalls his experience of visiting his daughter in a specialist unit: "[i]t was like walking into an Ethiopian famine; they were all skeletons, they were all high achievers, some were accountants, some were dentists, some were top business people."

4.2.3 Identity and voice

Identity

Identity is a significant factor for almost all of those who experienced an ED; being defined by the ED is a very common characteristic. The importance of empowerment appears as a prominent theme amongst all those who deem themselves to be in recovery from an ED. The components of recovery include the importance of respect, finding one's voice and feeling heard. For almost all of those who experienced EDs, the need for certainty and a low ability to tolerate distress around uncertainty impacts on issues of identity. The majority of those who experienced EDs explain how their lack of identity added to their feelings of worthlessness during the worst stages of the disorder. Ruth says, "I had no idea who I was, I felt like invisible, I felt like a ghost, I didn't know who I was, I didn't know who I wanted to be, I tested out identities and just felt like I was completely lost." The majority of those who experienced EDs and spoke of recovery also spoke of a sense of grief over having to let go of the ED identity. When considering the ED identity, Graham explains it is "very difficult to disentangle." For approximately half of those claiming insight, there seems to be an understanding of the rigidity involved in EDs which makes issues of identity difficult and the prospect of change, at times, unbearable.

From the perspective of those who experienced EDs, approximately a quarter suggest that being reassured of their purpose in God has been an integral part of their recovery journey. Karen explains, "[s]o my faith at every juncture has informed my journey and my understanding of my ED, because, how could it not? It's an intrinsic part of me and who I am." Common to approximately a quarter of those who experienced EDs, there is a tendency to use scriptural verses or Bible-based promises as a mantra for self-worth. Lucy emphasises, "I am valuable, I have meaning, I am chosen, I do have a purpose, that's all God." There is a consensus amongst approximately two-thirds of those claiming insight that identity is a problematic issue. Half of those claiming insight suggest that for those experiencing EDs, church community could provide safety, belonging and an identity as part of a larger family.

Finding voice in recovery and feeling heard

There seem to be two parts to finding one's voice: the aspect where one can talk about the ED and a further stage where one can stand against injustice and speak up against potential oppression. Almost all of those who experienced EDs refer to at least one occasion of not feeling heard and subsequently interpreting this as a judgement of their worth. Ruth explains how repeated incidences of feeling 'shut down' and not being permitted to speak at vulnerable stages resulted in a belief that "my feelings aren't valid." Karen explains that "[t]he whole 'not being heard' thing is very much rooted in my family upbringing environment, that certainly filters into a lot of other areas, and I find that quite hard." The inability to voice one's needs is linked to subservience and not feeling heard. For almost all of those who experienced EDs, subservience is the path of least resistance. Ruth explains: "it's so much easier to be the quiet fixer who nobody really ever hears." As an integral part of recovery, it seems that finding one's voice is a crucial part of rehabilitation. Elizabeth expresses her feeling "a need to find me, and my voice and be comfortable with me and my voice and my views on things." Almost all of those who talked about their personal recovery also spoke of finding strength through overcoming the fear of talking about their distress. Carole illustrates this: "I knew if I didn't talk to anyone, I had let it get to the point where, if I didn't talk to someone, I don't know what I would have done." The need to consistently make efforts to find one's voice is deemed essential, but a constant struggle for approximately half of those who experienced EDs. For approximately one-third of those who experienced EDs, being

authentic and honest with oneself is an integral part of finding one's voice. Kathryn shares that "being very honest with people [is important], if someone upset me, I would probably tell them immediately. Before, I would just have thought, 'I don't want to let them know, I'll just let it be.'" The majority of the carers appear to have a personal conflict between feeling as if they are disempowering their loved one as they speak up for them, and the desire to protect and be the voice for their loved one, particularly during periods of intense vulnerability.

Personification of the ED

In the majority of the interviews, often two voices are talked about: the voice of the ED and the woman experiencing the ED's voice. Diana explains, "[it's] like [there are] two of me in there." Two-thirds of those who experienced EDs describe the ED as an entity in itself, sometimes given a gender; in a few instances they describe it as a female and in one instance it is described as a male. Most commonly, the ED was referred to as 'it' but, for a small minority, this formed part of a therapist's therapeutic method for recovery. By identifying her ED as 'him,' a separate identity to herself, Sarah says that "[i]n treating him as a person, I can separate him from my life and keep him at arm's length." Most often, the ED is described as another part of themselves which they are trying to fight. It is often described as forceful and as having control over the physical perpetuation of the disorder, functioning much like a dictator. Denise describes her experience, saying "ED controlled my emotions. ED controlled me. I hated him but needed him." Embarrassment over the acknowledgement of the presence of another voice is often prevalent; Diana shares, "I was going to say it's her voice, but you'd think I was really mad." The theme of speaking to oneself is common to almost all of those who experienced EDs.

Self-denigrating self-talk is particularly prevalent in the discussion of the ED voice. Karen comments, "I often would have been very harsh and scathing in how I referred to myself and how I communicated with myself." The propensity to punish and abuse oneself was common to almost all of those who experienced the ED voice. Lisa reports, "[I was] punching myself and [saying] 'why are you fat and why are you ugly?' It was just punishment, this is what you deserve, kind of thing. I hated myself so much, that's why I did it." For all of those who experienced EDs, there appears to be a dissonance between the desire to please others by

recovering and the inability to stop the behaviour. This dissonance often results in a subsequent increase in secretive behaviour which, in turn, increases feelings of self-hatred.

Almost all of the carers speak of the ED voice with a level of distress; Hester describes her experience: "she spoke of it as a person and I found that, to be honest, weird, I wasn't sure how to relate to that." For approximately a quarter of carers, the ED voice was given religious connotations and referred to as a harsh, demonic voice. Jane suggests that "she was held in this Satanic [sic], there is an evilness to me, there is an evilness that goes along with eating disorders." Philip further describes the distress involved in the voices: "you kind of thought your daughter's possessed 'cause when you think of voices [and the] devil and stuff." Dan, a carer, speaks of his consultation with an ED consultant psychiatrist: "I was asking him about the voices, and he called them tormenting thoughts, and it's a good description, and I asked him about these thoughts, he said they are not well understood." All of the carers express a perplexity in understanding the inner conflict and in particular the ED voice. Almost all carers appear to have distressing memories of observing conflict and dissonance between the body and the mind of their loved one. Contrastingly, approximately only one quarter of those claiming insight acknowledge an understanding of the ED voice and its impact on those who experience EDs.

Recovery and creativity

Three-quarters of the women who experienced EDs spoke of the sense of achievement and the therapeutic effect of various creative endeavours. Approximately half of the carers seem to be aware of creative media as a part of recovery for their loved one. Conversely, the stunting of creativity was referenced as an integral component to the perpetuation of the disorder. A variety of forms of creative expression appears to be therapeutic when shared with others for those who experience EDs. There are at least two aspects which illustrate the importance of creativity: as a distraction from the ED and secondly as an expression of emotion. Hannah narrates how she "used to sit there and make jewellery. Any time when I was fighting with mum and dad, it was the only time I wasn't thinking about it." Glenda describes her experience of using creative endeavours as a therapeutic medium with her counsellor: "I wouldn't have even been focusing on what I was painting, it was kind of like a distraction, so I was able to get everything out." The sense of achievement endowed through

creative endeavours was a factor which seems to have a profound effect on recovery for over half of those who experienced EDs.

The most common creative endeavour mentioned by those who experienced EDs is journaling; however, all of those who used journaling also found it helpful to share their journal with someone they trust. For approximately one quarter of the women who experienced EDs, there is a cathartic quality in journaling. On the other hand, creative media could also entrench individuals in their feelings of despair if it is a solitary exercise. Karen explains: "I couldn't find any words to articulate how I was feeling or express that, so it was just the page, it was just this massive dark scribble, there were no words to articulate that so I just scribbled on the page, black." Those who used journals as cathartic tools during the worst stages of the disorder expressed a present fear of reflecting upon their journals.

Almost all of those who referenced using creative media as a therapeutic tool said that human interaction is an essential part of this process. Only a small minority of those who claim insight suggest that creative media are a useful therapeutic tool, and those who do mention it are adamant that this can be a very helpful component alongside multidisciplinary care. Through a wider frame of reference, not explicitly inclusive of creative media, approximately two-thirds of those claiming insight suggest that expression of emotions is crucial in recovery. Jean suggests that, when being present with a woman who has experience of an ED, it is necessary to "[allow] her to express herself in whatever message she has and whether that's verbally or creatively, it doesn't matter."

Carers were the most frequent to comment on the intelligence and creative capacity of their loved ones; almost all referred to a certain giftedness and attention to detail. When reflecting upon the specialist inpatient unit that his daughter was part of, Dan shares that "[t]hey were all clever, articulate and highly gifted people but very demanding on themselves, very sore on themselves, perfectionists." Perfectionistic tendencies appear to be the qualities through which the curative element in creative endeavour can become distressing. Approximately half of those claiming insight recognise that perfectionistic tendencies cause those who experience EDs to have very high standards for themselves and others. Graham explains that

a perfectionistic tendency often "predisposes people towards an ED." The subject of perfectionism is further developed in the discussion of the theme of obsession.

4.2.4 Dualism and disconnection

Emotional numbness and dissociation

Two-thirds of those who experienced EDs suggest that, in the medical model of the NHS, there is a lack of willingness to engage with anything other than the physical symptoms. Karen explains: "I first went to the doctor when I was just probably turned eighteen, I was referred to the dietician who did nothing, it was ridiculous, 'eat three meals a day, keep your fat content below ten and that was it.'" Approximately three-quarters of those who experienced EDs reported instances of feeling a further sense of disconnection through the care they experienced. Glenda comments, "[l]ike you just kind of felt like a robot in a way, like, you went in, got weighed, and it was like, 'how are things this week?' Just very cold." A concentration on body weight alone and behaviour associated with this causes further emotional difficulties and increases a sense of emotional rejection. In contrast, over half of those who report the experience of pastoral care in churches suggest that there the attempts to enquire into their personal history were often unhelpful. Almost all who reference asking for help in church talked about the disconnect and chasm between statutory and church-based care. Karen comments on her experience of pastoral and statutory care: "[n]obody was really prepared to actually holistically deal with the whole thing, it was just one bit or the other, and that's why it never worked, it just didn't work."

Temporarily numbing emotions is prevalent amongst almost all of those who experienced EDs. Total disconnection from emotions appears to be a skill and a safety mechanism for approximately a quarter of those who experienced an ED. Insomnia and subsequent anxiety are a consequence of dissociative behaviour for all of those who referenced this. Those who referred to dissociation also commented on significant trauma in their past. Diana comments: "I would dissociate completely so I could be sitting having a conversation but I'm in the corner watching myself having a conversation." Almost all of those who experienced EDs refer to being emotionally numb and the majority comment on feelings of being disconnected from their body but don't necessarily use the terms dissociation or disembodiment. Jennifer

explains: “I have obviously learned to cope by numbing it out, I can be very, very calm, even when I don’t feel very calm.” Almost all of the carers note emotionless detachment at different stages along their loved one’s journey. Jane says, “I think she was still despondent really.” There is an understanding for approximately half of those claiming insight of the sufferer’s detachment from emotions. Jean states: “[o]ther ones feel that complete emptiness when they don’t want to do emotions; when they don’t want to be connected.” Approximately one quarter of those claiming insight suggest that detachment from one’s body and one’s emotions is especially painful during the most intense stages of the disorder. Graham explains that “the whole process of their recovery involves bringing together their body and mind and allowing one to help the other.” One quarter of those claiming insight suggest that increased feelings of connectedness between body and mind appear to help interrupt the obsessive cognitive cycle associated with the ED.

Polarised thinking

Polarised thinking is common throughout almost all of the transcripts of those who have experienced EDs; this is mainly linked to perfectionistic thoughts and subsequent feelings associated with failure. Sarah explains that one of the most dominant feelings is “a feeling of failure. So, if I ate a ‘forbidden’ food, I would have felt like I’d blown it anyway and gone on a binge.” Determination, obsession and fear of failure are also linked to polarised thinking as Karen explains: “we’re all or nothing – when I give my all to something then I give my all.” The propensity to categorise behaviour as all bad or all good is common for approximately three-quarters of those who experienced EDs. Binary thought is particularly common when assessing value associated with calorie consumption; ‘being good’ equates to not eating at all or eating low-calorie foods; ‘being bad’ relates to eating ‘forbidden,’ high-calorie foods. There is much difficulty accepting behaviour without appropriating an ultimate value judgement. For those who have experienced EDs, binary adjectives like ‘good’ and ‘bad’ are often correlated with extremes of emotions. Ruth explains that for her “[t]here’s no flexibility when you have an ED. It’s good and bad, even just you’re looking well, you’re a mess - you’re looking fat.” Similarly, the majority of carers suggest that, when their loved one’s ED was more severe, their thinking was more rigid and they were more apt to use more binary judgements in decision-making. At the most difficult stages of his daughter’s ED, Dan describes her

characteristics as “rigidity in her thinking, black and white thinking, feeling unloved and unlovable.”

Almost all of those who experienced EDs describe these extremities of emotional experience. Roberta explains the extremes of emotions when her ED was the most intense: “I would want to absolutely die at some points, and then at other points, I would be absolutely petrified that I was going to die.” For almost all of those who experienced EDs, there is an intense discomfort with the unknown and a desire to acquire certainty; often this accompanies a need for explanations. Categorisation and labelling appear to be a way of assessing levels of perceived threat for those who experience EDs. The sense of unsafe and safe categories is relevant to food, people and circumstances. Almost all of those who experienced an ED reflected upon using binary categories for their mind and body when their ED was at its most severe.

For those who embrace religious beliefs, there appears to be another realm of binary thinking which is used to categorise their worldview. Approximately a quarter of those with EDs reference the devil as an oppressive force with which it is necessary to battle. Lucy says that, in her experience, the ED always has “undercurrents of the enemy’s lies, identifying the lies.” Diana explains her issues with dissociation: “it’s almost as if ‘am I dead somewhere’ and my body is there, and it’s been taken over by the devil, and he’s pretending to be me, and that’s why I’m doing the bad things?” Almost all of those who mentioned personal religious beliefs referred to themselves as being ‘bad’ when measured by their perceived sense of religiosity. Furthermore, approximately half of the total interviewees suggest that repentance is another method of self-punishment and a cause of increased shame. Ruth suggests, “… [i]n that sort of way, repent, sins and hell you know it’s because you’re a bad person, you deserve this, it’s not God is testing you, it’s that God is punishing you.” With approximately half of those who experienced EDs, there is scepticism as to how religion and God could be helpful to recovery. Ruth compares her perceived sense of guilt, suffered through her religious experience, as comparable to the ED voice; she expresses “that Catholic guilt that’s so related to that guilt of ‘no you’re not allowed.’” Approximately one quarter of those who claim insight encourage a binary understanding of morality as a structure for life and a necessity in pastoral care.

Almost one third of those claiming insight would discourage use of moral value judgements in pastoral circumstances and deem this as unhelpful to the rehabilitation process.

Pastoral care

Approximately half of those claiming insight into church communities refer frequently to binary categories such as good and evil. Samuel explains that "the Bible talks about the devil being a liar and a tempter." Samuel further suggests that, in certain contexts, it would be helpful to understand the circumstance in a biblical manner, concerning light and darkness: "it's got the fingerprints of darkness all over it." Approximately a quarter of those claiming insight recommend that delineating clear moral boundaries is essential in pastoral care. A small minority suggests that using biblical quotations is the only benchmark and the best measure of how to interact in pastoral care. Harvey explains is view that "[t]he answer is, I'm only dealing with truth, and I don't care what you tell me, but this is what I'm seeing. And can I be transparent enough to say, this is what I'm seeing, so are you doing this now then the minute you go home making yourself sick or what are you doing?" The priority for this small minority is to explain the fundamental precepts of what they perceive to be 'the gospel message,' demarcating between truth and lies as an aid to pastoral care. Frances says, "I certainly wouldn't think it would be helpful to say there's neither heaven or hell there, neither good nor bad because to me that is telling lies because that is not the truth." Approximately one quarter of those claiming insight suggest that in pastoral care circumstances, failure to mention 'the gospel message' is a misuse of an opportunity.

Approximately a quarter of those who experienced EDs recall a heightened emotional state, a dramatic turning point. The majority of those who speak of this also comment on a salvation experience, from spiritual darkness to spiritual light. Lucy describes her turning point: "I saw God, I saw the enemy, I saw [sic] the voice, and I thought, right I'm going to take you out." For those who profess the Christian faith, the determination not to accept the ED's presence in their life is often accompanied by the metaphor of battle and, 'the enemy' is often used as a name to describe the force which is perpetuating the ED. Approximately one quarter of those claiming insight support this battle mindset. For almost a quarter of those claiming insight when someone persists in maladaptive behaviour, including EDs, there is a belief that this is 'rebellion' against God. Harvey comments that "often someone has a rebellious way,

and they couldn't possibly keep it up, but, the Scriptures are very clear, that a spirit that decides to go the opposite way often gets help from a spiritual authority elsewhere." Approximately one fifth of all groups alludes to one's spirit being oppressed or possessed by the devil and a quarter of those who experience EDs report distressing experiences of being prayed over in supposed efforts to remove demons. Diana describes her experience: "she was asking the demons to leave me, and then I started panicking and thinking 'there's demons in me, I'm cursed' you know what I mean." Fear was integral for almost all of those who referenced experiences of being 'prayed over.'

Approximately one third of those claiming insight suggest that categorising in black and white is unhelpful, especially in pastoral care. Siobhan explains that "… there's a lot of grey." When considering methods of caring for those with EDs, Lesley suggests, "it's trying to create that wholeness and oneness as opposed to duality." For two-thirds of those who experienced EDs, the duality of body and mind features alongside core issues concerning identity confusion. Approximately one quarter of those claiming insight into pastoral care suggest that body and spirit must not be separated, but rather looked upon as a cohesive whole, otherwise this creates a sense of duality.

4.2.5 Isolation

Relationship difficulties

Approximately three-quarters of those who experienced EDs suggest that the inner conflict permeates into their relationships in a destructive way, and difficulties with trust cause problems in relationships. For almost all of those who experienced EDs, high levels of sensitivity, especially during the most intense phases of the illness, make social interaction difficult. Self-created isolation is consequently an issue. The internalisation of others' moods and subservient compliance with those who would seem more powerful is a primary cause of isolation for almost all of those who experience EDs. Heightened sensitivity and a low ability to filter and recognise when emotions are subject to the moods of others is often disabling for almost all of those who experienced EDs. Diana explains: "it's like there are two of me, there's one of me that's so needy, then there's the other part of me that pushes everybody away and wants to be on my own." Abby further explains this difficulty in social interactions:

"I get lonely when I'm on my own but when I'm with people I can't wait for them to leave so as I can be on my own again." For three-quarters of those who experienced EDs, certain social circumstances are accompanied by feelings of uncontrollable anxiety. Roberta records that "physical symptoms, became, I guess, insanely intense, panic and anxiety attacks and they were quite debilitating, I stopped being out and about, I stopped putting myself in social situations, I couldn't cope with them at all." Approximately one third of those who experienced EDs report that social interactions caused panic and anxiety attacks. Denise explains, "I've like no confidence in myself, I don't know, even when I'm meeting new people, it's like I can't do this." Almost all of those who experienced EDs self-report low self-esteem and depression due to feelings of loneliness and rejection.

Relationship with family

For more than half of those who experience EDs there is anger linked to feeling misunderstood by their family and feeling not "good enough." A common theme of fear of rejection appears in almost all the interviews with those who experienced EDs and is observed by almost all of the carers. More than half of the carers themselves felt rejected when their loved one was experiencing an ED. The distress evidenced in family circumstances for almost all of those who experienced EDs often centred around the necessity for particular food specification and exercise requirements. Kathryn comments on how the ED affected her relationship with her family: "it made me resent them because I associated them with making me eat stuff I didn't want to eat." The emotional ramifications of this are extremely distressing for those experiencing the EDs. It also appears that the majority comment on complicated relationships with their mothers, which is ironic as mothers are often the primary caregivers. Karen explains: "my mum, and she still does this, rather than considering how that situation is for you or how that is making you feel, she would take that on herself as in, how could you do that to me and how could you say that?" Approximately half of those with EDs note a relationship between being able to express themselves in their family relationships and recovery. Healthy rapport in the maternal relationship seems of particular importance in recovery.

Suppression of emotions

Approximately three-quarters of those who experienced EDs spoke of intense fear and experiences of emotional numbness. When asked about how she felt, Ruth reponds, "[w]hen [the ED] was at its worst, nothing, absolutely nothing, and I loved it. The point of it was to flatline, and to not feel anything." More than half of those who experienced EDs also comment on their low ability to articulate, and, in some cases, identify emotions and respond accordingly. In common with more than half of those interviewed, Jennifer replies, "when you ask about emotions, I find it very hard." Chloe similarly explains, "I still find emotions very difficult to deal with," and Carole further relates, "I couldn't express my problem." One quarter of those claiming insight appear to have some understanding of the silence, difficulty in talking about emotions and subsequent isolation which often accompanies those with EDs. Sinead explains that "they tend to be introvert, they don't really share a lot with people, they tend to carry a lot themselves." For those with EDs, there appears to be a common thread among almost all of those interviewed that at some stage of their journey they have felt 'shut down' with a significant period of silence often following. Approximately one quarter of those claiming insight appear to understand that quite often those with EDs have tried to talk about difficult issues but felt 'shut down' and mention the damaging effects which are a result of this. Claiming insight, Jean suggests that many women who have gone through trauma will say,

> 'but nobody listened,' 'they didn't believe me,' 'I couldn't tell, I was told to keep it a secret.' And it is about a safe space and saying this is your safe space and you are allowed to tell whatever it is, be yourself, release yourself of the burdens and I think that's important.

The need for feeling safe in recovery and free from the projection of others is a theme which repeatedly appears in over half of the transcripts of those claiming insight. Carole explains that safety will be integral in exploratory spaces "where they can be who they want to be."

4.2.7 Compassion

Understanding and empathy

In more than half of the interviews with those who experienced EDs, there appears a common theme of surprise when they have been understood and and respected as an equal. Denise explains her perception of her work colleagues: "[t]hey're very good in tolerating me, I think it's because I'm such an annoying person, to think that they even tolerate me and tolerate my silliness or my chattiness, they just listen to me, they're very empowering." Half of those claiming insight mention the importance of respect and acceptance. David explains that "if there isn't that opportunity for the person to be accepted, respected and listened to, I think it's much less likely that whatever the intervention is [it is] going to be effective." Siobhan suggests that the core principles in the creation narrative suggest that all beings deserve to be "treated with respect."

Almost all of those who spoke of rehabilitation comment on a gentleness in words used, tone and behaviour in those who helped in their recovery. Hannah explains her experience with her therapist: "I think it was probably just her friendly tone of voice and stuff, she never shouted or anything." Glenda describes why her partner is especially helpful in her recovery: "[h]e really took the time to understand why I felt the way I felt." This sense of being understood is imperative to recovery for all who experienced EDs and spoke of recovery. In contrast, almost all of those who experienced EDs recall times when a lack of understanding, avoidance and hurrying rehabilitation was especially unhelpful. All who spoke of repeated relapses and a lack of recovery consistently recalled not feeling adequately understood. Helen illustrates how her husband's low ability to understand the nature of the ED had an adverse impact on her recovery; she explains that "he had and has currently no concept of what I would call pain. I maybe sound over-dramatic here, but it is a physical pain when you are trying to overcome an eating disorder." Jennifer explains what she deems to be the cause of her suppressed emotions: "[m]y parents don't think mental illness really exists."

From a carer's perspective, in a reflection of their initial understanding of the illness, there appears to be significant remorse. Philip comments, "I didn't understand it's a mental issue, it's not Hannah's fault, and there was me shouting at her." All of the carers describe helplessness and subsequent bewilderment as their personal experience. Approximately one

quarter of those claiming insight into church communities appear to have more of an empathetic connection with the families of those affected by EDs than the individuals themselves. Frances comments that it is positive, "[i]f they want to say to their family that they're sorry that they've caused them all these problems." The understanding from this particular group is akin to placing total responsibility and blame on the individual for their illness and their recovery. Three-quarters of those claiming insight into church communities view the disorder and recovery from the disorder through a wider perspective, encompassing factors such as abuse which may have been out of the control of the individual experiencing the ED. The issue of taking responsibility appears to be a complex issue which, on the one hand, can incorporate blame and feelings of shame, and on the contrary, can be used as an empowering factor in acceptance. Graham explains: "I see EDs as being very understandable, sophisticated, complicated ways that people try and manage their lives." Approximately three-quarters of those claiming insight emphasise the need for understanding and empathy, but also express a need to know their limitations and timing for a referral to specialist care.

Compassion and recovery

Self-awareness and an acute ability to sense the emotions of others seems to be particularly prevalent in those who referred to past traumatic experiences. Joy comments, "I would actually be quite discerning; as I can tell straight off is someone is being genuine or not." There appears to be an innate sensitivity in almost all of those with EDs to detect a lack of authenticity, consequently causing a retreat. This self-imposed safety behaviour appears to be damaging in relationship building, but it also reveals a high level of intuition and perhaps an over-sensitivity to the possibility of judgement by others. Trust appears to coincide with sensing authenticity, as Sarah explains: "I have a great counsellor who specialises in EDs, I trust her. She is a very real person." Trust also appears frequently alongside safety; both are deemed imperatives in authentic communication. Carole explains that "when we encounter any pastoral care relationship with compassion we begin to know we're safe and it's only when we begin to know we are safe that we are going to begin to explore our story."

Half of those who experienced EDs recall unhelpful encounters with people who wanted to 'fix' them. In contrast, being supported and feeling understood is much more helpful in recovery. Carole explains her reason for choosing a confidant: "I knew he wasn't trying to fix

me, I knew he was just going to listen and pray with me." The sense of others wanting to fix the problem appears to evoke anger in approximately one third of those who experienced EDs and one third of those claiming insight also recognise this propensity to 'fix' others in church communities and suggest that this reflects an inability to connect with their emotions. Charles comments, "I don't know if the church is good at that in terms of having people connect to emotions. I think the risk is that, rather than listening, that people want to fix each other." Conversely, a third of those who experienced EDs appear to be helpless, exhausted and exasperated with their illness and want to be rescued. Diana explains: "it's just like the wee person that was me at four is stuck down there, and nobody can get to her. If somebody could just put their hand down there and just lift her out, but nobody's been able to." Attentive listening appears to be one of the most positive responses when it comes to the involvement of others in recovery. Sarah explains that she has "a supportive husband who knows everything and has never, ever judged me. He is a great listener." Understanding partners and close friends appear to be the most therapeutic relationships which aid in recovery. The ability to accept and feel love is also a therapeutic feature in the restoration of those who experienced EDs. As Roberta reflects, "I guess he actually loves me." For all those who experienced EDs, trust appears to be synonymous with compassion and is essential to feeling safe enough to share their story.

There is a striking pattern for all those who spoke of recovery, in that, as self-compassion increased, the tormenting thoughts about food and exercise began to lessen in intensity. Noticing the critical nature of the ED voice and identifying it as separate from one's identity are significant factors for all those who spoke of recovery. Louise explains: "I suppose just the compassionate voice that says, 'You know, Louise, you're all right, you're panicking, but you're all right, it'll be okay.'" For half of the carers, knowledge of the love of God or Jesus is personally strengthening, and love and compassion is an integral part of being a Christian. Dan relates his experience of being still before God: "we relax in the surprise of being loved." Approximately half of those claiming insight determine that compassion should be an essential part of Christian pastoral care as it is definitively "the heart of the gospel." Carole explains: "[compassion] ought to be the primary mode of interface among us as Christians, among the church, the primary mode of interface between the church and the world, so therefore it's got to be the primary mode of pastoral care." Christine also suggests that

genuine care takes shape "through encouragement, not condemnation, but encouragement, you know, and love. Show love." The observation of acts of compassion, being a recipient of acts of compassion or participating in acts of kindness to others, are instrumental in recovery for those with EDs.

Awareness and acceptance

Throughout the findings, awareness is often identified as being a forerunner of acceptance, and the ability to notice emotions is particularly relevant for over half of those who spoke of their own personal recovery. Over half of those claiming insight comment that the awareness of one's emotions is crucial to recovery. Graham explains that "it's about learning how to attend to the present moment if it's about being aware of your thoughts and feelings without judging them; if it's about learning to accept who you are in the moment and not to fight that too much." Being self-aware enough to be able to identify and discern what is safe and what is unsafe is also identified throughout the transcripts as an aid to recovery. Approximately one third of those claiming insight differentiate between self-awareness and self-dependence, believing that dependence should be on God. Approximately three-quarters of those claiming insight deem unconditional positive regard and a sense of acceptance of the individual as being important to recovery. Jean explains: "I think acceptance, accepting the woman for who she is and being able to offer a safe environment and to listen." From a carer's perspective, all interviewees deem the sense of accepting their loved one unconditionally to be linked to love and the necessity to reassure them by offering long-term stability. Hester reflects that "it's showing her that she's totally accepted how she is and that people, even if it's one person, will be with her for the long haul." For those with EDs, the sense of permanency in acceptance is imperative to those who have spoken to others about their ED. Helen explains her experience with a caregiver: "she understood, she was like a neutral ground … she would listen without judgement." More than half of those claiming insight deem it necessary to listen non-judgmentally in pastoral care circumstances. However, only approximately a third of those claiming insight mention self-awareness or self-reflexivity as a necessity component in recovery.

4.2.2 Subsidiary themes

The subsidiary themes are classified as important due to the frequency of their occurrence; like the core themes, these are not mutually exclusive. Again, they appear to be related to each other and are permeable. However, these themes were not unanimously deemed as equally important to each group, unlike the core themes. The aim of this section is to convey two important themes which have emerged out of a notable frequency of references from the experiences of all those interviewed. The details documented under each theme will also seek to portray the idiosyncrasies and nuances of each group. Relevant parent nodes in order of their frequency of appearance will function as an outline to aid in understanding how these themes are formed.

4.2.1 Views on the church as supportive to recovery

Perspectives on church communities and pastoral care

Approximately half of those who claim insight recognise that fear of judgement and feelings of rejection are significant factors for those who experience EDs. Approximately one third of those who claim insight recognise that judgemental attitudes can be part of particular church communities. Similarly, approximately one third of those who claim insight explain that rigid church communities could increase feelings of shame in women experiencing EDs. David suggests that "if people have assumptions that we're all sort of bad and evil which, if you're already feeling like that, you'd be more open to hearing that and that being reinforced." Approximately one quarter of those claiming insight suggest that particular churches have very strict rules around morality and endorse public shaming as a pathway to repentance. Samantha explains: "if someone is seen to breach those rules, then there is a public and a punitive redressing of that." Aspects of power and control as linked to church and religion are referenced by approximately two-thirds of those who experienced EDs. Louise explains that, "religion for me is like a reason to go outside yourself to look for some answers outside yourself, for me that is what it trains people to do, God, did it fail! It failed dramatically for me." Almost half of those who experienced EDs suggest that the idea of searching outside oneself, as linked to religion, is comparable to surrendering power through subservience to others.

Approximately one quarter of those claiming insight recommend that Bible passages are a fitting and helpful aid to recovery, validated by the belief that it is first necessary to confront the sin in order to promote repentance before there can be recovery. The same group use a binary categorisation labelling those who repent and turn away from their sin as 'saved' and those who don't as 'lost.' A small minority of those claiming insight holds the perspective that those with EDs are being "punished" for their "rebellion" against God. Those who repeat words which allude to punishment and sin are more apt to quote or paraphrase the Bible repeatedly as evidence to support their claims. In contrast, two-thirds of those claiming insight emphasise that the primary goal should be to get the individual well and not to concern oneself about other categories of thought, including religious concepts and language. Carole comments that "often theological terms are so weaselled with different meanings, conflicting meanings, and a sense often of otherworldly judgement or fear which is neither necessary or helpful." More than half of the women with EDs who spoke of pastoral care experiences, to "repent," "pray more" or "tell God," are adamant that these were not helpful experiences.

Conversely, approximately half of those claiming insight suggest that God could give a sense of purpose and the church community could provide mutual support for that identity. David explains: "you can be given a sort of ready-made identity … you can immediately feel that you have a role and purpose and are valued in different ways." Approximately one third of those claiming insight explain that even in churches where there is a very rigid system of rules, this can provide a sense of a family environment. Samantha records that "it's very, very collective, great sense of ownership, being an insider and strong family." The majority of those who encourage trusting God and being part of a church community suggest that this gives a sense of purpose and meaning to life, and a small minority explains that their faith in God has been a vital part of their recovery. An even smaller minority suggests that their experience in a church community was integral to their recovery. Aoife shares how this helped her from a perspective of identity, support and guidance: "you're not going to figure out what you'll do with your life until you're in community and people bring it out of you." For almost all of those who experienced EDs, general human interaction and authentic connectedness appear as a significant factor in recovery. Approximately half of those claiming insight suggest that the Bible-based purpose of a community is, in practice, non-existent in many churches.

Charles comments: “I think the church mistakes fellowship for being in the same place at the same time doing the same thing. Which is not the same thing as community.” Approximately half of those who experienced EDs suggest that in church community, they see an in-group and out-group distinction linked to the ‘saved’ and ‘lost’ category of conditional acceptance. The necessity of diminishing the in-group/out-group distinction appears to be a necessity in pastoral care for approximately a quarter of those claiming insight.

Religious and spiritual practices

Approximately one quarter of those who experienced EDs found prayer to be one of the most supportive gestures to help people feel loved and cared for. Aoife comments that “it’s just knowing that there’s people out there who are praying for you and caring.” Over half of the carers were significantly dependent on their personal prayer lives and the prayers of others as a way of getting through their loved one’s illness. Sandra explains that “I pray every day, and it did help me to stay sane.” The theme of religious practices keeping carers “sane” was important for over half of the carers. Prayer, in particular, is seen as a marker of commitment to God by approximately a third of those claiming insight and as important in recovery. From a position of insight, Christine comments, “God does not need us to pray, but God wants us to pray because it shows him how committed we are and how much we mean business.” In contrast, for three-quarters of those who experienced EDs, personal prayer has been especially difficult.

For approximately one third of those claiming insight, Bible reading and prayer appear to be the most commonly encouraged practices as aids to recovery, and one third of those who suggest scripture reading as important in pastoral care, appear to use a particular set of scripture passages that could help those with EDs. Cathy comments that when interacting with those experiencing EDs, “[t]he girls who would facilitate in the one-to-ones, they would have lists of different scriptures that they would use.” Two-thirds of those claiming insight urge caution when using scripture and prayer, rather a simplicity is encouraged. Samuel comments that there must be sensitivity to the struggle, in particular concerning “the fear of God, of kind of Him condemning them.” Anger linked to coercive methods in Christian pastoral care was commented on by over half of those who experienced EDs. Louise explains: “It’s the attitude that this is it or nothing, it’s all about reading the Bible and somebody else’s

interpretations, and it's very little to do with your own inner system, your own soul." Approximately half of those who experienced EDs experienced disingenuous and manipulative religious behaviour as particularly off-putting. For more than half of those who spoke of pastoral care experiences, these were in differing measures deemed as damaging and often led to further self-abasing behaviour. The findings suggest that for three-quarters of those who experienced EDs, Scripture reading has been particularly difficult during dark stages of their ED. A small minority reported Scripture reading as helpful to their personal recovery. Karen explains: "I felt like I just couldn't genuinely come to God because I was in such a mess." Disconnection from God was common for almost all of those who experienced EDs, which was underpinned by feelings of worthlessness.

Meditative practices appear to be helpful for approximately half of those who experience EDs; often this is non-religious. Approximately half of the carers find value in Christian-based meditative practice, as Dan explains: "we would attend daily Eucharist, we would try to spend nearly an hour a day in contemplation." Only a small minority of those claiming insight mention meditative practices, and the majority of those who mention meditation appear to be distrustful of organised religion. There is a particular leaning towards silence for approximately a third of those who have experienced EDs. Helen comments, "my preference would have been just to go to an empty chapel during the week and in the evening time when it was completely empty, when it was completely silent, not even have to say prayers."

Forms of meditation appear to be a significantly important factor for almost half of those who experienced EDs; the meditative factors in yoga, in particular, appear to be a significant aid as a regular practice. Roberta comments, "[i]t's about the ability to quieten the mind, to feel what's going on in your body, to feel what's going on in your mind, the ability to be able to switch off from stress or anxiety." For one quarter of those who experienced EDs, regular yoga practice is instrumental in recovery, through an ability to connect with the body, silence anxious thoughts and connect with the breath. Helen explains that "you're not focusing on what have I eaten today, how many calories have I taken in, what am I going to eat today? There's none of that." A sense of achievement and consequent increase in self-esteem appears to develop symbiotically with yogic practices. Only a small minority of those claiming insight suggest that being aware of the breath and the connection with the body is a factor in

recovery. A sense of spirituality is important for two-thirds of those who experienced EDs, but this was not associated with a church or God in most cases, but rather more commonly linked to a feeling of connectedness with oneself and others. Roberta explains: "[m]y spirituality comes through bigger picture thinking, is it relevant? Can you change it? Does it benefit anything other than yourself?" The sense of seeing a bigger picture for their lives was common to all of those who spoke of recovery.

4.2.2 Views on statutory care as supportive to recovery

Statutory Care

Approximately three-quarters of carers and those experiencing EDs were unhappy with aspects of the statutory care they received; waiting times for treatment were a particular concern. Specialist care, in the majority of cases, appears to have been helpful for those who experienced intense periods of anorexic behaviour and a clinically low BMI. In particular, a 'wrap-round treatment' is noted as especially useful and a positive experience of statutory care. The stability, consistency and depth of understanding offered as part of the care they received, seem to be major factors in all of those who spoke of recovery. Almost all spoke of BN and AN existing at different stages of their experience and sometimes co-existing. For those who predominantly had BN, specialist care with a counsellor or in-patient treatment was often only received when they presented with a comorbid issue such as borderline personality disorder, bipolar disorder or clinical depression. On the advice of her community psychiatric nurse, one woman who experienced an ED, but was not under the specified weight for specialist care, was advised to conduct an online course alone in an NHS building. Kathryn comments:

> I don't think the online programme helped at all, because like I probably should have been like talking to someone; because I wasn't underweight I wasn't prioritised kinda thing. So, I was just like sat in front of a computer. I have the manual and things at home, I think I only went to like four out of eight sessions of that, and then I just stopped turning up, and no one like asked me why I stopped turning up.

The necessity for more community-based help for those experiencing mental health issues was mentioned by approximately half of those claiming insight. In accordance with this

mindset, the prerequisite of safety occurs as a constant theme throughout the transcripts. Recalling her personal experience, Carole says, “it’s only when we are with somebody that we know they care, when we’re with someone they know they’re not alone, it’s when we are with somebody that, if we’re a safe presence, that they [sic] know they [sic] are safe.” Most often there appears to be a consistent theme of recovery when there is an emotional connection with one person in a care team in particular. A sense of empowerment through knowing that another human believes in the potential of the person experiencing the ED and encourages that ability to flourish as a creative human being, have been imperative to all who spoke of recovery.

Negative care-receiving experiences in interactions occur particularly when those with EDs have felt objectified. Objectification is evidenced through examples of medical care teams focusing on their body weight without adequate understanding of their personhood, thoughts and feelings. Extreme cases of this are in a small minority but are documented as a form of verbal abuse. Lucy recalls her interaction with a psychiatrist: “he verbally abused me, he put me down, not really what you want to do with an anorexic … he looked at me and said, ‘you’re nothing but a good-for-nothing anorexic and that’s all you’ll ever be.’” The feeling of being objectified in care, as the body is treated in a purely a biological manner, appears to be a significantly negative factor for those who experience EDs. The majority of reports of care received from GPs was negative; over half of the carers comment on feelings of frustration and exasperation at not being heard. Philip comments, “we had three GPs with Hannah, and they were as useful as a chocolate fire guard, you know, and a shame on the lot of them and it’s horrific, it’s horrifying what I hear now.”

For those who referred to experiences of being in specialist units, there is a consistent pattern of repeat admissions. Lucy suggests that specialist units become places to learn from more seasoned anorexics: “I came out of the unit, I had lost four stone in the space of four months, I was good at it now, I was a professional at it now, I had learned everything.” There appear to be mixed opinions in those who experienced EDs regarding the effectiveness of specialist units. Conversely, more than half of the carers speak very determinedly regarding the need for a specialist unit in NI. Dan describes his experience of observing his daughter’s care in a specialist unit and believes “they saved her life,” while also relieving family distress through

resting in the knowledge that she was being looked after. Nonetheless, the experience after leaving a specialist unit for EDs is recognised as difficult when it comes to reintegration into the family and community. Dan explains: "when she left The Priory after eight or nine months and came home, the struggle continued." Carers often view statutory aftercare after periods in a specialist unit as insufficient.

Half of those who experienced EDs complain that there is no consistency in statutory services. Almost all carers are vehement that statutory care is not sufficient. For approximately half of those who experienced EDs, the temporary and somewhat cold nature of some experiences of statutory care is a destabilising factor. Roberta comments, "I know people who get seen every two to three weeks; they have a conversation, they're weighed, and they're sort of sent off into the world again, being told, 'if you don't eat you're going to get sick.' Tell me something I don't know." The absence of adequate resources for those experiencing EDs is commented on by almost all of the carers.

Community-based support and collaborative care

Acute care is deemed a necessity by all of those interviewed. Notably, however, three-quarters of interviewees believe that improved community-based help could be helpful to recovery, particularly in signposting and in supporting carers. More than half of the carers speak of ED-specific, community-based help being essential as a source of information and guidance for them, but also as a vital initial stepping stone resource while on waiting lists and as a link towards receiving statutory specialist care. This desire for better community-based services also appears to be linked to unhelpful experiences with GPs. The experience of speaking to an individual who has either had a child with an ED or who has experienced an ED themselves was particularly useful in community-based organisations. There appear to be deeper connections and more lasting relationships with those in community groups than those in statutory services.

Alternative forms of non-specific community-based help, including church-based support, appear to play a temporary role for approximately a quarter of those who experienced EDs. The community-based support aids human interaction and acts as a preventative against isolation. When there is a lack of understanding and difficulties in communication, this causes

those who experience EDs to retreat from community and lose confidence in their ability to form relationships. From a carer's perspective, all agree that a collaborative care team is necessary for recovery. Philip explains: "for any parent out there I would say you will never do it on your own, you need the whole, you know, collaborative care." Approximately two-thirds of those claiming insight would agree that there does need to be a more joined-up approach to care in general for mental health. David comments:

> In general, mental health services need to be working in a much more collaborative way and systemic way with everybody involved with the person they are involved in working with. Whether that's, as will often be the case, their family and/or whoever they're, sort of, working with, in or through a church organisation.

Church-based collaboration

Approximately two-thirds of those who claim insight emphasise that there is rich secular thought about EDs which must be taken into consideration when caring for those experiencing EDs. The majority also insist that Christian spirituality is a crucial component to recovery. Sinead explains: "I do think, in that context, that Christian counselling can bring that extra dimension that secular places won't touch." For one third of those claiming insight, there seems to be a resentment and a belief that many secular therapies cut God entirely out of the equation. Frances comments, "I still think that the care provided by the church should be different and should be distinct because the emphasis in the church is as Jesus as your healer." Although there is a distinctive difference in the approach to care used by the NHS and church communities, there is a similarity in their desire to help. There is a recognition from two-thirds of those claiming insight that specialist care is an imperative when caring for those experiencing EDs, yet my findings suggest that there are few established care pathways between churches in NI and the NHS. In a minority of cases, however, there appears to be an adoption of a referral pathway from Christian counselling to secular care as a set protocol in circumstances where severe mental health issues are detected. Nonetheless, from the perspective of those who claim insight, there is a consensus that there could be an absolute helplessness and an inability to know how to care due to lack of experience with EDs. Sinead explains: "I think the sensitivity shown by our choice of language is an incredibly powerful yet underestimated thing in society as well as the church, because the church have their own

language." Within the two dimensions of secular care and Christian spiritual care, there is a desire for training on communication methods. Approximately half of those with insight recognise that an understanding of the impact of words is necessary; religiously-orientated words used in pastoral care can cause particular difficulties for those recovering from mental health issues. According to approximately two-thirds of those claiming insight, training is deemed essential to increase awareness and sensitivity.

4.3 Conclusion

Although there is much in common between existing literature and my findings, neglected themes such as do exist such as the relationships between power and control, voicelessness and vulnerability, disembodiment and disconnection and creativity and recovery. Furthermore, although there is much to be commended in reports of care, there is an urgent need for increased skilfulness in pastoral care and more resources in statutory care. In Chapters Five and Six, I will elaborate on the connections and interplay between the three groups, particularly when considering the themes which are relevant to those with EDs but appear as neglected themes in the primary thematic findings of carers of women who experienced EDs and those claiming insight into both EDs and church communities.

Chapter Five: A critical conversation with sagely wisdom and prophetic discernment

5.1 Introduction

The most salient themes from the interviews with women who have experienced EDs, carers of women with EDs and those who claim insight into church communities will be discussed, critically analysed, compared and contrasted with the existing literature. Similarly, to the presentation of the findings, the boundaries between the themes and the key areas are permeable and, in some cases, overlap. The interrelatedness of the themes and the areas will be described and explained as similar or distinct, where relevant. Further, throughout these conversations the importance of the Church recognising neglected themes will be emphasised through the section on the research findings. The existing literature from feminist theology will provide a bridge to further development of thought in Chapter Six.

The discussion is presented as four brief, bilateral conversations between:

5.2 The research findings and the existing literature on EDs

5.3 The research findings and the existing literature on fundamentalism

5.4 The research findings and the existing literature on pastoral care

5.5 The research findings and the existing literature on feminist theology

5.2 The research findings and the existing literature on EDs: Introduction

There are various themes, as highlighted below, which were particularly significant in my findings and especially relevant to the discussion on how to provide appropriate care in church communities. The most important of these will be further explored in Chapter Six. The themes which will be discussed in the chapter are:

1. Control and oppression
2. Distress
3. Trauma
4. Relationships
5. Identity
6. Spirituality and religiosity

5.2 1 Control and oppression

Relevance

Almost all of the women who experienced EDs indicate that the lack of control leads to a sense of internal oppression, external oppression and a sense of being imprisoned in their bodies. Throughout the findings, the desire to please appears to be closely linked to fear and feelings of inferiority in response to those in powerful positions especially prominent in the lives of those who referred to abuse.

Response

EDs are a practical response to an extreme sense of lack of control in one's life (Bell, 2014; Bruch, 1974). As the control of body weight reflects a longing to regain control of one's body, theories on objectification are also relevant in this discussion (Fredrickson and Roberts, 1997). Existing research supports the sense of loss of control combined with feelings of helplessness (Rollero and De Piccoli, 2017). Research supports the propositions that those who have experienced EDs report an increased fear of losing control of themselves (Tiggemann and Raven, 1998). An increasing number of studies indicates that those who experience EDs commonly suggest that the ED provides a sense of control, structure or willpower to their lives (Patching and Lawler, 2009; Espindola and Blay, 2009). Fairburn, Shafran and Cooper (2003) explain that this behaviour occurs in the absence of adaptive personal control strategies in an effort to regain self-esteem and a sense of control.

Similarly, Rørtveit, Åström and Severinsson (2009) found that women experiencing EDs feel imprisoned in their bodies are are more likely to perceive themselves as controlled by others (Tiggemann and Raven, 1998). In accordance with Bruch's (1978) observations, many of those interviewed who are experiencing EDs are not free to be who they are, rather they try to comply with the image others have of them, which leads to the difficulties experienced in self-objectification. Related to the theme of submission, the majority of those who experienced EDs also spoke of a desire to please others, often at the expense of their own well-being. Noordenbos (2013) explains that those experiencing EDs are often afraid to express their feelings and thoughts and try to conceal them from others, especially when they feel these views might be divergent from what others feel or think and suggests that those

with EDs adjust as much as possible to feel valued for their people-pleasing behaviour, and behind this is a core lack of self-esteem. Furthermore, feminist theory and critical social theory supports this finding and suggests that there is a strong correlation between socially imposed hierarchical structures of power and women's subservient behaviour (Smolak and Levine, 2015). Throughout the interviews, feelings of oppression were always correlated with increased sensitivity and extreme fear. This is supported by research which corroborates the argument that punishment sensitivity is an issue in those experiencing EDs (Harrison et al., 2016).

As supported by Brewerton (2017) and further confirmed by this research, the most common traumatic experiences are sexual, emotional and physical abuse. Existing research corresponds with these findings as the prevalent rate of physical abuse is 32.3% and, of sexual abuse, 47.7% amongst those who experience EDs (Claes and Vandereycken, 2007). More specifically, a study by Carter et al. (2006, p.257) demonstrates that "[t]hirty-seven patients (48%) reported a history of CSA [childhood sexual abuse] before the onset of the eating disorder." The findings by Carter et al. (2006, p.257) correlate with my findings as they suggest those who experienced EDs and childhood sexual abuse have "significantly greater psychiatric comorbidity, including higher levels of depression and anxiety, lower self-esteem, more interpersonal problems, and more severe obsessive-compulsive symptoms." Cotter, Drake and Yung (2016), however, suggest that although it is accepted that childhood abuse may feature as a factor in the aetiology and development of psychiatric disorders, its correlation to long-term psychopathology remains unclear. Van der Kolk (2014) suggests that when abuse in childhood is not processed and integrated into the psyche it can compound difficulties in adulthood and reveals itself in bodily responses. In such cases, there is often an immense struggle to self-regulate emotions which subsequently triggers maladaptive coping mechanisms, such as an ED (van der Kolk, 2014).

Renvoize (2017) supports this finding that sexually abused girls are more prone to engage in binging and purging behaviour than their non-abused peers. Carter et al. (2006) concur with this conclusion and propose that sexual abuse is more often linked to binge and purge behaviour than those who predominantly engage in restriction. Approximately half of those who spoke of abuse in their interviews commented that these experiences were not isolated,

rather, varying types of trauma have been repeatedly experienced. Van der Kolk (2014) suggests that these recurrent happenings relate to theories of re-enactment. Re-enactment theory explains that the individual is compelled to place oneself in circumstances which cause a repeat experience of the trauma and revictimisation. There is a small amount of research available on this area and further study is needed to identify and establish the correlation between adulthood revictimisation and the course of the illness among those with EDs (Cotter, Drake and Yung, 2016). Self-blaming is consistent with the research on EDs and abuse (Brewerton, 2017). Irrespective of the cause of family difficulties, research suggests that the maintenance of a sense of security and protection is crucial for healthy development (Rothschild, 2010).

5.2 2 Distress

Relevance

My findings suggest that, alongside shame, almost all the women who experienced EDs also reported experiencing depression, anxiety, feelings of loneliness and rejection. Approximately half of those who experienced EDs suggested that the pain of managing and expressing distressing emotions can, at times, be almost unbearable. Approximately one-third of the interviewees referred to self-harm in the form of NSSI as a comorbid characteristic alongside the ED being connected to intense regimes of self-punishment and self-hatred as part of their ED behaviour.

Response

In accord with Stoeber et al. (2016), all of the women I interviewed experienced unrealistic expectations, fear of others' scrutiny, and harsh self-criticism linked to perfectionism and shame proneness. The relationship between shame and EDs has been recognised since early case descriptions of ED sufferers and has been identified both in general populations and in clinical populations with EDs (Gilbert and Miles, 2014). As affirmed by Oldershaw et al., (2015), almost all of those who experienced intense levels of shame mentioned feeling profoundly inferior in comparison to others, as they perceive themselves as defective, worthless or as failures. In agreement with Doran and Lewis (2012), my findings suggest that the consequences of intense shame cause a further inability to express emotions which, in

turn, causes emotional isolation. Klump et al., (2009) support my findings and suggest that the most common comorbid conditions associated with shame-proneness are depression and anxiety. These findings are further substantiated by meta-analytic evidence which concludes that shame is a core contributor to depression (Kim, Thibodeau and Randall, 2011). As mirrored in the findings of Mills et al. (2015), almost all of the interviewees who experienced EDs also reported periods of feeling depressed, most of which commenced in adolescence. In common with Szentágotai-Tătar et al. (2015), my findings suggest that shame is an all-encompassing construct that at times is confused with guilt. Notably, however, as Levinson, Byrne and Rodebaugh (2016, p.188) clarify, "[s]hame, but not guilt, prospectively predicted both social anxiety and bulimia symptoms." My findings correlate with most of the recent literature that has focused on deepening the relationship between shame and appearance-related aspects of the disorder, such as dissatisfaction with one's body and body image concerns (Marta-Simões et al., 2016).

As supported by Bailey and Waller (2017), Rienecke et al. (2016) and Lang et al. (2016), this distress increased in certain social circumstances, yet ironically building relationships was also noted as a key component in their recovery. Alexithymia is commonly reported in ED literature, and studies demonstrate that inhibited emotion is linked to misconceptions regarding the implications of emotional expression in social contexts (Westwood et al., 2017; Oldershaw et al., 2015; Barth, 2016). Inhibited emotional responses which are linked to fear are highlighted in the research of Dakanalis et al. (2016) and are known to influence behaviours and decision-making, which can potentially overwrite the logical or cognitive responses. Oldershaw et al. (2015) suggest that due to an inability to effectively regulate emotions, when strong 'primary' emotions arise, they are often suppressed. As a consequence, 'secondary' emotions arise, of which shame is a prime example and a constant feature in all of the women in my research who experienced EDs. As demonstrated by Oldershaw et al. (2015), for over half of the interviewees who experienced EDs, recalling the emotions experienced in traumatic events is immensely painful and is often a primary cause of avoidance and silence.

Jacobson and Luik (2014) suggest significantly higher statistics of NSSI as associated with EDs than were reported in my findings. My findings suggest that two-thirds of interviewees

describe their ED behaviour as a form of self-harm, whether through restricting or binging and purging. Although this behaviour is harming to oneself, research more commonly defines self-harm as non-suicidal self-injurious behaviour. Claes et al. (2010, p.386) suggest that "[c]utting and scratching were the most common forms of NSSI followed by bruising and burning oneself." Almost all of those who referenced NSSI commented that this served as an alternative mechanism for regulation of emotions. These findings are consistent with existing research studies (Gonclaves et al., 2016) which indicate that purging and NSSI may serve similar functions to manage emotions and regulate affect.

My findings suggest that NSSI is more common with those who predominantly report BN, which is further supported by existing research (Jacobson and Luik, 2014). My findings indicate that three-quarters of those who referenced NSSI are also those who experienced abuse. In alignment with these findings, Gonclaves et al. (2016) suggest that those who have experienced abuse, as a group in themselves, have elevated levels of NSSI risk and are more vulnerable to NSSI behaviours. Therefore, it is difficult to decipher whether the ED behaviour causes self-harm or whether abuse is the precipitating factor. On the whole, my findings contribute to the definite correlation between sexual and physical abuse, NSSI in individuals with EDs (Gonclaves et al., 2016; Steiger and Thaler, 2016). There is, however, still much research required to develop more effective models for the management of emotions and regulation of affect.

5.2.3 Trauma

Relevance

Linked to the desire to feel numb, many of those who experienced EDs report that their feelings of intense shame, inferiority and dirtiness often make them want to hide or disappear. My findings suggest that almost all describe an emotional numbness as the desired state when their ED was most severe. A small minority of women linked this to dissociative experiences, however, although only a small minority explicitly used the word 'dissociation,' it is likely that more women have experienced this state but did not use this specific terminology.

Response

Research supports that, if there is a history of trauma in those experiencing EDs, it becomes harder to attend to their perceptions and sensations (Howell, Elizabeth and Sheldon, 2016). Approximately one quarter of those who experienced EDs suggest that they have practised behaviour that effectively shuts off their emotions, as particularly during the worst stage of their disorder it was preferable not to feel any emotion. Vanderlinden et al. (2016) support this finding and suggest that traumatised individuals often cannot tolerate bodily sensations because of their intensity, and consequently many deliberately detach from emotions by self-imposed emotional numbing. This coincides with existing research, as often after a period of emotional suppression, everyday emotional experiences can become unmanageable and terrifying (Petrucelli, 2016).

Like many studies, my findings confirm a definite correlation between traumatic experiences, dissociation and EDs (Howell, Elizabeth and Sheldon, 2016; Thornley, Vorstenbosch and Frewen, 2016). As reported by Koskina, Mountford and Tchanturia (2016), my findings reflect that there is a significant relationship between psychological dissociation and body dissatisfaction which contributes to body image vulnerability and self-objectification. Almost all of the women who experienced EDs talked about their body in a denigratory manner as if it were an entity in itself, separate to their being. Research suggests that this is linked to concepts which involve a person's subjective emotions concerning their body image. When there is a disconnect between the integration of emotional experiences of one's body in response to cultural ideals, a disruptive form of self-objectification occurs, and sometimes dissociation (Tiggemann and Slater, 2017; Fardouly, Willburger and Vartanian, 2017). Petrucelli (2016, p.20) explains, "[a]n eating disorder symptom is not just something to get rid of – but rather – something to profoundly understand as it holds dissociated parts of oneself and one's relational history." This suggests that there is a meaning behind the ED symptoms and, rather than being alienated and labelled as bad, these symptoms should be explored as potential keys to unlock the cause of distress. My findings support the view that there is a definite link between self-objectification and dissociation which is not thoroughly documented in existing research and could be further explored.

5.2.4 Relationships

Relevance

My findings indicate that over half of those who experienced EDs felt such intense levels of incompetence and worthlessness that they could not interact socially. The desire for love, yet the inability to accept love because of feeling undeserving of it in close relationships, is a consistent theme throughout all of the interviews with those who experienced EDs. Furthermore, my findings suggest that almost all of those interviewed who have experienced an ED have also experienced conflict and a lack of attachment to parents during the course of their ED.

Response

Gorka et al., (2017) and Eneva et al., (2017) underpin my findings, which suggest that, for almost all of those who experienced EDs, high levels of sensitivity, especially during the most intense phases of the illness, make social interaction difficult. Many experts believe that overcoming relationship difficulties is the key to recovery, therefore, treatment programmes in ED are beginning to target this area (Treasure and Schmidt, 2013; Fairburn et al., 2015). The precise nature of social difficulties and how they contribute to the prolongation of EDs urgently requires further research to improve treatments. Hudson et al. (2007) confirm that social anxiety constitutes the second-most prevalent anxiety disorder that co-occurs with EDs. Levinson and Rodebaugh (2011, p.38) argue that "[w]e do not find support for either social anxiety or eating disorder symptoms per se predicting each other across time. Instead, we find that some underlying vulnerabilities prospectively predict symptoms of both disorders." Therefore, it would seem that there are particular sensitivities in women experiencing EDs that originate in childhood (Kaye et al., 2004). Levinson and Rodebaugh (2011, p.27) confirm that "social appearance anxiety and fear of negative evaluation are vulnerabilities for both social anxiety and eating disorder symptoms." Consequently, anxiety centred on social evaluation by others is often perpetuated by rigid belief patterns and inflexibility (Maraldo et al., 2016). In agreement with Arlt et al. (2016), my findings indicate that inhibited social functioning is also linked to an internal cognitive rigidity that dictates what is allowed and not allowed.

As supported by Doran and Lewis (2012) and Behrendt and Ben-Ari (2012), my findings demonstrate that self-created isolation and subsequent feelings of loneliness are reportedly an issue for almost all those who experienced EDs. Martin, Plumb-Vilardaga and Timko (2014) propose that shame-proneness can lead to interpersonal alienation as a person may try to avoid triggers of potentially shaming situations. As confirmed by Troisi et al. (2006), there is a significant correlation in my findings between those who are insecurely attached and those who have high levels of body dissatisfaction. Kuipers et al. (2016) further affirm these findings and suggest that instead of forming healthy bonds, they are more likely to isolate themselves and suppress emotions or tend to over-attach to significant figures in their lives while finding emotions overwhelming. Bowlby (2012) and Allen (2016, p.64) argue that, "following placement with a supportive caregiver," symptoms reduce.

Cantón-Cortés, Canton and Cortés (2016) suggest that interparental conflict can be the cause of emotional insecurity. In particular, those children endangered by destructive conflicts are at a greater risk of presenting a high reactivity and developing insecure representations of relationships and maladjusted regulating to conflicts. Evidence referring to attachment theory and EDs demonstrates that there are high levels of conflict, insecure attachment and low cohesiveness in family relationships (Tambelli et al., 2015). My research also indicates that for one quarter of those who recovered in adolescence, family support is particularly important in recovery. There is much evidence to confirm that the family provides an essential supportive function which is often a major aid to adolescent recovery from EDs (Lock and Le Grange, 2015; Rienecke, 2017). This is also evident in the NICE (2017) treatment guidelines for those under eighteen, as many recommendations integrate the family including The New Maudsley Approach for Carers (Treasure, Smith and Crane, 2016).

5.2.5 Identity

Relevance

My findings indicate that identity formation is a particularly notable developmental challenge for those who have experienced EDs. The majority of those who experienced EDs and spoke of recovery also spoke of a sense of grief over having to let go of the ED identity. My findings demonstrate that determination, obsession and fear of failure are linked to rigidity which

appear particularly pronounced in those presenting with co-occurring disorders. The rigidity involved in EDs makes issues of identity difficult and the prospect of change, at times, unbearable.

Response

In accordance with psychoanalytic research, my findings support the argument that the aetiology of EDs is connected to the mind-body split in the separation-individuation process which causes identity diffusion (Granieri and Schimmenti, 2014). As affirmed by Malson et al. (2011), the majority of women who experienced EDs comment that, at the worst stages of the disorder, the ED entirely eclipsed their identity. Bruch (1974, 1978) argues that the ED is compensation for the absence of identity. In agreement with Polivy and Herman (2002), my findings suggest that many of those who spoke of recovery alluded to "finding themselves", thus implying a journey linked to identity. As Verschueren et al. (2017) explain and my findings also imply, during the course of their ED the majority of women have experienced intense anxiety, insecurity, feelings of low self-esteem and rumination, therefore identity diffusion is most likely a useful umbrella term to correlate similarities. Although functioning as a separate construct, low self-esteem and unhealthy ego development is thought to compound difficulties associated with identity (Corning, and Heibel, 2016, Armstrong and Roth, 1989). There appears to be a distinct gap in research, particularly when looking at the underpinning processes that contribute to identity difficulties. This may indicate an area for potential development.

Cognitive inflexibility is considered to signify low awareness of resolutions when unanticipated changes in one's environment occur, and a low ability to adapt in response to these changes (Arlt et al., 2016). When assessing the subjectivity in those presenting with cognitive inflexibility and the behaviour of set-shifting, those experiencing EDs perform sub-optimally in contrast to healthy controls shifting (Roberts, Tchanturia and Treasure, 2016). Feelings associated with being out of control combined with fears of uncertainty are clearly evidenced through my findings. Those interviewed displayed increased rigidity in order to regain a sense of control, as reflected in current research (Frank et al., 2012). A possible explanation for polarised thinking is linked to existing research conducted with individuals with AN, highlighting the presence of an inefficient cognitive processing style described as

weak central coherence (Lang et al., 2016). My findings suggest that almost all of those who experienced EDs have focused attention to detail which often becomes obsessional and preoccupies their entire thinking. My findings also indicate that there is a certain propensity to engage in dualistic thinking patterns. Issues relating to control, including weak central coherence partially explain these difficulties. This, however, requires more research to address the binary thinking patterns of those experiencing EDs.

5.2.6 Spirituality and religiosity

Relevance

Approximately one third of those who experience EDs found the idea of God being omnipotent as robbing one's agency, because this would necessitate a surrender of locus of control. In contrast, approximately one quarter of women who experienced EDs highlight the view that being reassured of their purpose in God has been an integral part of their recovery journey. Approximately half commented upon being subject to disingenuous and manipulative behaviour in Christian churches. A sense of spirituality was crucial for almost half of those who experienced EDs, but this was not associated with a church nor with engagement with Scripture in most cases; rather, it was more commonly linked to a sense of transcendence and a feeling of connectedness with oneself and others.

Response

The formative role of religiosity and spirituality in women experiencing EDs has recently been presented in a number of research studies (Doumit et al., 2017; Hall and Boyatzis, 2016; Richards et al., 2006). Research indicates that religion can have a contentious relationship with well-being, but spirituality most often moderates the symptoms of EDs and has a particularly beneficial effect on self-esteem (Henderson and Ellison, 2015). In significant contrast to pre-existing research, my findings suggest that the majority of those who professed a Christian belief did not believe that their religiosity was a major influence in reducing symptoms of their ED. Through a meta-analysis of thirty-one studies, Martinez, Smith and Barlow (2007) confirm the benefits of spiritually-based psychotherapy, including the development of more meaning and purpose in life, distress tolerance skills and, by consequence, reduced ED symptoms. Again, in contrast to this research, my findings suggest

that those who experienced EDs offer mixed views on religiosity and spirituality, with approximately two-thirds rejecting extrinsic forms of religiosity as unhelpful. The type of religious experience described by the women who have experienced an ED suggest a repulsion against fundamentalist traits rather than against spirituality in general, or the healthy forms of religiosity that are most often considered to have a positive correlation with recovery (Doumit et al., 2017).

Studies suggest that there is a crucial correlation between 'intrinsic' religiosity (in contrast to 'extrinsic' forms), and anxiety, which could decrease vulnerability to EDs (Doumit et al., 2017). Those who practice 'intrinsic' religiosity have fewer symptoms than women who are engaged in religious endeavours for 'extrinsic' motivations (Smith, Richards and Maglio, 2004; Doumit et al., 2017). Contrary to my findings, existing studies confirm that a secure relationship with God and a reassurance of God's purpose for one's life is associated with lower ED symptomatology, including decreased levels of body dissatisfaction (Hall and Boyatzis, 2016).

My findings suggest that certain aspects of religiosity, including the propensity to feel shame and guilt through disobeying God, has particularly negative impacts on self-perceptions of body image and often cause more deleterious cycles of eating behaviour. Conversely, previous research indicates that belief in God as the creator of one's body, combined with the belief that God can comfort and reduce fear, are associated with reduced eating pathology and decreased body dissatisfaction (Hall and Boyatzis, 2016; Buser and Parkins, 2013). Although this applies to a small minority of those who experienced EDs, approximately three-quarters of this group were more avoidant when discussing their relationship with God. This avoidance would signal that fear- and shame-based religious conditioning are particularly prevalent in NI and an area in which fundamentalist-like Protestants and conservative Catholics are similar. Marsden, Karagianni and Morgan (2007) argue that engaging in negative religious coping feelings of shame, guilt and an overwhelming sense of sinfulness, can cause withdrawal from community. This indicates that much research needs to be carried out on negative religious coping in an NI context.

A small minority of those who experienced EDs reflected upon their experiences of worship and small groups as helpful in their recovery. Smith et al. (2003) suggest that church

communities can provide safety for young women, increasing self-esteem and their capacity to develop healthy relationships. Homan and Boyatzis (2010) propose that an insecure attachment to God increases ED symptomology and therefore it is not surprising that women who are insecurely attached to God often mention fear, shame, potential for rejection and anxious thoughts when reporting their understanding of this relationship (Richards et al., 2006). Kent (2013) observed that women had an increased vulnerability to ED symptomology if they experienced caregiving experiences that included feeling judged or criticised by their religious community. Consequently, there needs to be more research into why there is inadequate support in church communities in an NI context.

Liturgy including prayer and scripture reading especially within a supportive community could be helpful for those experiencing EDs (Henderson, 2014). Furthermore, prayer in general, whether personal or communal is helpful in generating positive emotions for women struggling with EDs (Hall and Boyatzis, 2016). Meditative practices, including silence and contemplation, appear to be useful for approximately a quarter of those who experienced EDs. However, these are not always in Christian forms. Studies support the view that certain meditative techniques are effective in the treatment of EDs (Baer, 2015; Doumit et al., 2017, Hempel, Vanderbleek and Lynch, 2017). There is little research exploring the impact of Scripture reading on ED recovery, although Boyatzis et al. (2007) indicate that the preliminary findings in experimental research suggest that reading scriptural texts could help decrease body dissatisfaction. Furthermore, research suggests that religious teaching assists individuals in developing a sense of intimacy with God (Buser and Benard, 2013). Within an NI context, it appears that there is a significant propensity towards negative religious coping. Approximately one quarter of the women I interviewed described dysfunctional religious behaviour, including "trying to be good," motivated by a fear of punishment, which clearly signifies negative religious coping (Pargament, Koenig and Perez, 2000). Despite the extensive amount of research on the correlation between religiosity, spirituality and mental health, few have explored the correlation between religiosity and EDs and thus future research in this area could potentially be a valuable contribution to the ongoing discussion.

Conclusion

My findings confirm that shame-proneness in those experiencing EDs can lead to feelings of unworthiness and emotional avoidance that are sequentially linked to low self-esteem (Tanaka et al., 2015) and emotional dysregulation (Behrendt and Ben-Ari, 2012). As Petrucelli (2016) explains and my findings reflect, the ED is not merely something to get rid of, but rather the behaviour indicates much about emotions and past unresolved experiences. Although my findings indicate that only a small minority of women found comfort through involvement in religious communities, existing research suggests that participation in religious communities should provide support for recovery and purpose for life. Therefore, the following conversation synthesising fundamentalism literature and my findings, will help clarify which areas are particularly detrimental to recovery when caring for those experiencing EDs and the significant similarities between some traits of those in fundamentalist movements and those experiencing EDs.

5.3 The research findings and the existing literature on fundamentalism: Introduction

Many of the experiences that fundamentalists experience are consonant with those affecting individuals who have experienced EDs. In this conversation, five areas that reflect relationships between fundamentalist movements and those experiencing EDs will be discussed:

1. Power and patriarchy
2. Polarised thinking and rigidity
3. Emotional reactivity
4. Identity in community
5. Inhibited creativity

5.3.1 Power and patriarchy

Relevance

Power and control are significant factors in the lives of all interviewees who experienced EDs, as the majority report that they have the propensity to follow authoritarian leadership. This is evidenced by both reports of an authoritarian internal voice and damaging power dynamics in social relationships. In a reflection of personal experiences of the religious fervour of fundamentalists, approximately half of the women interviewed who experienced an ED described circumstances where church leaders or members have tried to manipulate and emotionally shut them down. The dangers of combining these two are obvious. For approximately half of these women, there is notable anger related to issues of power and control when speaking of religion, church and God.

Response

Authoritarian leadership takes the form of hearing an internal critical voice, which functions much like a dictator. Aldridge (2007, p.131) describes the dogmatic authoritarianism common to fundamentalists as "… a pathological mutation of faith.". Strozier (2017) argues that the fundamentalist dogmatists similarly exhibit bully-like behaviour and intense anger when they feel their sense of control is removed. Issues of anger and control are evidently significant contributors to maladaptive behaviour of both fundamentalists and those who experienced EDs.

Although fundamentalism might provide feelings of security for the in-group, this is conditional upon adherence to the select rules and is thereby fear based (Lassander and Nynäs, 2016). Therefore, fundamentalism's performance-related values do not provide the comfort of an unconditional genuine love, inclusive of faults and failings, which is necessary for a true sense of healthy emotional security. Consequently, it would be unlikely that those experiencing EDs could find a sense of authentic safety in fundamentalist communities. Reflecting the insights on power from Altemeyer, Hunsberger and Paloutzian (2005), McSkimming (2016) also explains how individuals can become engaged in the power constructs within fundamentalist movements, and an identity can be formed in response to this which promotes subordination, subservience and subjectivity. Iman et al. (2017, p.24) explain that "[s]hutting down space for dissent and discussion, and curtailing freedoms of expression and association, are not only symptoms of religious fundamentalisms, but are also a facilitating factor in their rise."

While religious questing is viewed positively as something constructive and aligned with human flourishing, "[f]undamentalism can be viewed as a relatively closed system that tends to conserve prior meanings and rigorously controls new input from outside the system, suggesting that it could be considered an opposite religious motivation to quest" (Aten, O'Grady and Worthington, 2013, pp.78-79). Just as Kruglanski and Webster (1996, p.103) refer to "[a] need for cognitive closure" when there is a decreased motivation to think constructively, individuals in fundamentalist movements often prefer directive, authoritarian leadership to firmly lead them forward (Schumpe et al., 2017). Misuse of power through domination notoriously culminates in adherence to rules through fear in fundamentalists (Strozier, 2017), and the manifestation of continuous feelings of fear was also dominant in all of the women I interviewed who experienced EDs.

As supported by Bendroth (1993), approximately three-quarters of all of those whom I interviewed mentioned that they could recall experiences of an imbalance of power in relation to gender in churches. It is not surprising that the majority of the women I interviewed who are recovering from EDs deemed religiosity as irrelevant to their lives and suggested that dogmatic forms of religion could be potentially damaging to their recovery.

As supported by Bebbington (2013), approximately a third of those claiming insight mentioned that the misuse of these distorted forms of religious authority to manipulate and oppress women is still a prevalent concern. Isherwood (2008, p.51) links our oppressive Christian heritage to the issues of control and feelings of disempowerment in those experiencing AN: "[j]ust as secular patriarchal societies do not expect girls, who are the vast majority of anorexics, to show assertive behaviours, so the Church did not expect women to be assertive within it." MacArthur's contention noted on p.58 explains the corrupting effect on vulnerable women in fundamentalist churches in NI who, in many cases, have been subjected to varying forms of oppression and emotional abuse. As submissive behaviour is part of the behavioural requirement for women in a fundamentalist community, gender inequality is closely related to identity (Bendroth, 1993). De Beauvoir's (1952) *The Second Sex* appears to be relevant to both women in fundamentalist communities and to almost all women interviewed who experienced EDs as they describe feelings of imprisonment in their body. Furthermore, when compared to the literature on the subservience of women in fundamentalist groups (Iman et al., 2017), there is a distinct correlation with the evidence that women who have experienced EDs frequently feel disempowered by being pushed into submissive positions. The environment of fear as cultivated by oppressive leadership in fundamentalist communities would inevitably prove to be destructive for those who are vulnerable, particularly women experiencing EDs who are seeking nurture and security to recover from their disorder.

5.3.2 Polarised thinking and rigidity

Relevance

In common with fundamentalists, almost all of the women I interviewed who experienced EDs are also predisposed to divide the world into comprehensible binary distinctions. Self-persecution, which is evident in those who experienced EDs, is also familiar to fundamentalists. The women I interviewed who experienced EDs reported the same contradictory qualities of desiring to have clarity and create clear rules to live by yet being unable to adhere to their self-imposed perfectionistic standards and all of the women described occasions of self-loathing when the rules were broken. Most frequently, the

women I interviewed described their ED as another part of themselves against which they were trying to fight; they described this as a constant battle.

Response

Although contemporary fundamentalism is a product of modernity, fundamentalists fight against modernity with the objective of reversing its impact and influence and consequently they are compelled to embody a dualistic position (Marty and Appleby, 2004). As noted on p.48, psychologists who study fundamentalism point to dualistic thinking as its core characteristic. In psychoanalytic theory, this behaviour is referred to as 'splitting', which is defined as the failure in one's psyche to integrate the dichotomy of negative and positive characteristics of oneself and others into a cohesive whole (Klein, 1946). The extremist thinking which is characteristic of the defence mechanism of splitting is common to almost all of those who were interviewed and experienced EDs. Through dividing and polarising their beliefs, especially concerning food and exercise, they created the illusion of safety. Theorists suggest that fundamentalists' polarised beliefs are a product of repressed trauma and a natural response to fears associated with the feeling of threat (Ellens, 2017). Kenny (2015, p.183) explains: "splitting intensifies when the bad experience becomes overwhelming and unmanageable. The bad object is repressed (i.e. removed from consciousness) but its influence results in a rigidity of mind and fundamentalist thinking."

As mirrored by fundamentalist experience, and supported by Stein (2003), three-quarters of the women I interviewed also describe experiences of extremities of emotional experience, especially when their ED was most intense. Similarly, Armstrong (2000) explains that the fundamentalist's black-and-white worldview takes a vow, however unrealistically, to accept no shades of grey. Despite the desire to be 'black and white' in thought patterns, fundamentalists are often accused of hypocritical behaviour and hiding their contradictory behaviour (de Wit, 2016). For individuation (Jung, 1939) and self-actualisation (Maslow, 1943) purposes, each individual needs to learn distress tolerance skills that help with acceptance of non-absolutes and discomfort with the unknown. Fundamentalism makes such learning very difficult and can only inhibit the recovery of women experiencing EDs.

As Morris (2008, p.108) explains, the Gnostic and fundamentalist desire to escape from the physical body, as they both maintain a "deep distrust of the body and its functions … The emphasis was upon denial of pleasure." The distrust and hatred of one's body was common to approximately three-quarters of the interviewees who experienced EDs. When the body is viewed as evil, fundamentalists adopt a dualistic moral worldview and deprive the body to enrich the soul; this often results in devastating ramifications (Hawley, 1994). Although self-flagellation and other displays of mortifying the flesh have decreased in twenty-first century Christianity, fundamentalists still associate holiness with a denial of pleasure (Bendroth, 2016).

For religious fundamentalists, although the anger is normally not self-directed, the language used is often fuelled by anger directed at those who present what they deem to be a 'liberal' theology. However, denigrating terms such as 'worthless,' 'worm,' 'nothing' and 'hypocrite' are common as part of the language used in worship, prayer and preaching in fundamentalists' services. Wilson (Bebbington and Jones, 2013, p.148) explains that "the language used in discussing the threat to faith posed by liberalism was an aggressive one." Furthermore, Bendroth (2016, p.342) explains that the agitation and fury directed at the sins of modern culture are often caused by unresolved feelings of anger. The difference between fundamentalists and the women I interviewed who experienced EDs, was the direction of the aggression; more often for those experiencing EDs it is inward, while for fundamentalists it is outward.

Fundamentalists notoriously use the imagery of warfare in fighting against "the world, the flesh and the devil" (Bendroth, 1993, p.19), emphasising separation from the secular world and their desire for a theocracy of perceived righteousness using anger as fuel to perpetuate the battle. Furthermore, Herriot (2008, p.86) explains that fundamentalists experience "frustrated rage and humiliation at their inability to fight back effectively." Harris (1998, p.2) defines fundamentalists as an "extremist" subset of evangelicalism. As Garrett (1998, p.xiii) notes, "[a]n eating disorder is itself an extreme form of desire: a spiritual craving expressed through the body." The tendency towards extremism evidenced by fundamentalists was common to all of the women I interviewed who experienced EDs; they explained that often a normal diet gradually became an extreme obsession, although, when

considering notions of good and evil, the majority of these women did not interpret their actions as demonic or evil. It seems particularly significant that approximately a quarter of carers and a quarter of those claiming insight whom I interviewed explained that the ED voice could be interpreted as a demonic or evil force. The issue of referring to demonic forces is a potential problem and will be discussed further in the following discussion on pastoral care.

Marsden (1980, p.4) defines fundamentalism as "militant opposition to modernism". As fundamentalists fight against the perceived threats of the world, those experiencing EDs fight a similar battle to maintain and protect their perceived truth: they must be rigid in their adherence to conformity, discipline and order (Hansen and Ryder, 2016). Inflexibility and rigidity are characteristic of those who are part of fundamentalist movements (Strozier et al., 2010; Zhong et al., 2017; Barr, 1978). These traits are also common to all of those I interviewed who experienced an ED. The anger and hostility as documented by Armstrong (2000) are reflected in the cognitive rigidity and obsession commented on by approximately two-thirds of the women. Furthermore, Inozu, Koranic and Clark (2012) comment on a similar obsession in the fixations of those attracted to fundamentalist movements. As proposed by Altemeyer, Hunsberger and Paloutzian (2005), the unjustified certainty of fundamentalists is also an attraction for almost all of those who experienced EDs, as almost all comment on an intense discomfort with the unknown. Unsurprisingly, the prospect of acquiring certainty appears to be a comfort to the majority of those who experienced EDs. Categorisation and labelling appear to be a way of assessing levels of perceived threat for those whom I interviewed on their experiences of having an ED. The sense of unsafe and safe categories was recalled as being relevant to food, people and circumstances. Imam et al. (2017) explain that a curious sense of safety is sought in religious fundamentalism precisely because of the need for certainty.

For the women I interviewed who experienced EDs, adherence to rules often causes an increase in their self-esteem, and these traits are reflected in fundamentalist behaviour (Herriot, 2007; Hood et al., 2005; Strozier and Boyd, 2010). Although strict adherence to rules and regulations often temporarily alleviates the anxiety and low mood experienced by both those experiencing EDs and those in fundamentalist communities, the relief experienced is often short-lived and requires more restrictive rules in order to maintain the feelings of

achievement. Just as those experiencing EDs often retreat into isolation, Philips and Ano (2015) explain that fundamentalists also assume a defensive position, and rigid norms may be seen as a sanctuary (Lassander and Nynäs, 2016). Similarly, all of those interviewed who experienced EDs found a sanctuary in the rules associated with their ED. For all of the women I interviewed, the private nature of the ED often provides a refuge which has the distinct appeal of non-dependence on others. Although the appeal of fundamentalism is often centred around finding security in community, the fanatical approach to faith in God can promote an ethic of non-dependence on others, especially those outside their distinctive group. The segregation from outside influences often has an isolating effect which adds to the narrow mindset of fundamentalists. Wrench et al. (2006) suggest that fundamentalists forcefully refuse to accept that there are other ways to understand the world. The narrowing of perspective appears to be a distinctive characteristic of both those who experienced EDs and of fundamentalists. All of those who spoke of recovery from EDs also referred to the manner in which the lens enlarged as they recovered, and they were subsequently more able to enjoy a more vibrant life while holding supportive relationships. This indicates that isolation and restrictive rules are not conducive to the recovery of those who experience EDs. Saroglou (2016, p.34) explains that the lack of compassion in fundamentalists should not be attributed to their religious belief but rather "in psychological terms, to underlying personality factors other than religiosity, such as authoritarianism or cognitive rigidity." Cognitive rigidity as linked to a lack of compassion, is common to almost all women interviewed who experienced EDs and is explored further in the following section on emotions.

5.3.3 Emotional reactivity

Relevance

The fear of being judged, perfectionistic tendencies, combined with the fear and distress of letting others down, is evident throughout all of the interviews with those who experienced EDs. These characteristics perpetuate very strong emotions, in particular shame when standards are not reached; therefore, it is not surprising that that acts of confession and repentance are perceived by three quarters of interviewees as having the capacity to cause of increased shame.

Response

Religious beliefs have a massive influence on shaping emotions, thoughts, motivation and behaviours (Saroglou, 2016). As Lifton (1999) explains, for fundamentalists, emotions are diminished as unreliable or as a result of provocation from Satan, which significantly affects interpersonal relations. This inhibited emotional response is mirrored in all of the women I interviewed who experienced EDs. Fundamentalists who exhibit rigidity have lost the ability to self-reflect and thus become incapable of showing authentic empathy, resulting in a more critical disposition (Strozier, 2017). Indecision and an inability to choose for oneself are linked to numbness in women with EDs and this is mirrored in many of those engaged in fundamentalist communities. King (2009, p.177) explains that the fundamentalist's state of being "emotionally constrained" causes indecision and increases the propensity to follow those who appear as dictatorial-type leaders. As Bauman (1998, pp.73-74) argues, "the fundamentalist is saved, not only from sin but from the agonies of perpetual choice." When emotionally numb, almost half of the women I interviewed exhibit similar patterns of subservience.

Wallace (2016, p.1) claims that "[j]udgmentalism is the casual willingness to condemn, ridicule and deride others." He (2016, p.20) explains, "shame is derogatory judgmentalism directed inwards; bullying is derogatory judgmentalism directed outwards." McSkimming (2016) remarks that those who have reflected on their experiences of fundamentalism explain that they are not simply subject to the judgements of others, but they also exercise the same form of judgement on themselves and others. Strozier (2017) links shame to humiliation and paranoia as a distinctive trait of those involved in fundamentalist movements. Approximately one third of those interviewed who claim insight recognise that shame is often misinterpreted when interlinked with religious views and has the potential to be reinforced by religion. Wallace (2016, p.19) suggests that:

> [s]hame is judgmental ridicule and derision directed against ourselves rather than against those we reject as 'outsiders'. When we give way to this inward judgmentalism, we define ourselves as 'outsiders'. We make ourselves feel that we don't 'belong' in some invisible way that is available to everyone else.

In a pertinent article in *Christianity Today* titled "The Loneliness of Shame," Thompson (Moll, 2016, p.63) writes: "the emotion [of shame] is the most isolating – and also the one that real community can heal." Tragically, three-quarters of all three groups of interviewees suggest that shame in particular causes immense difficulties in social interactions, as feelings of worthlessness negatively affect the self-esteem of those who experience EDs. When considering fundamentalists' understanding of sin and the contents of sermons regarding the sinfulness of humanity, it is likely that feelings of shame would increase with exposure to such communities. Consequently, the potential for rehabilitation in such communities seems relatively low.

When considering fundamentalism, Helm, Berecz and Nelson (2001, p.26) suggest that

> [a]s the Christian church pushes for higher standards, a better ideal self, it may be producing more shameful people. However, since perfection is impossible, the striving for perfection creates a spiral of unrealistic and unreasonable expectations that cause feelings of shame and guilt.

The majority of the interviewees claiming insight used an illustration of the atonement of Christ as an example of the liberation from guilt and shame which is a significant factor in the language of many fundamentalists (Marty and Appleby, 2004). For fundamentalists, the blood of Christ is a dominant image in almost all worship, prayers and sermons and is often used to remind congregations of their need to feel guilt over their wrongdoing and consequent need for salvation. When considering the particular sensitivity and levels of shame described by almost all of the women I interviewed who experienced EDs, increased feelings of guilt are destructive to well-being and therefore unhelpful to recovery. Conversely, the love of Christ, including concepts of forgiveness and salvation, could well be helpful as curative components of the Christian faith which could help in recovery.

5.3.4. Identity in community

Relevance

A minority of the women I interviewed confirm that their sense of belonging in a church community was integral to their recovery, while the majority felt more ostracised from, than

included in, the church community. Approximately half of the women I interviewed who experienced an ED, referred to deliberately surrounding themselves with people who enabled their behaviour and did not help with their recovery. This behaviour was possibly subconscious but certainly a notable factor in the perpetuation of the disorder.

Response

Identity is not easily separated from community in fundamentalism. As shame and fear contribute to feelings of ineptness, the motivation to attain an identity outside fundamentalist movements is considerably reduced, thereby maintaining their allegiance to the movement (Strozier and Boyd, 2010). Fundamentalist communities' strength is often deemed to be their strong identity, a sense of a family environment and belonging. In agreement with Ruthven (2005), approximately half of those I interviewed who claimed insight suggest that church community could provide a sense of identity for those experiencing mental chaos. Bebbington and Jones (2013, p.147) explain that "[o]ne aspect of fundamentalism which women in particular appreciated was the opportunity it offered for meeting like-minded people … friendship and sense of community … women, therefore, played a significant, if primarily supportive role in fundamentalist organizations." For almost all of the women I interviewed who experienced EDs, general human interaction and authentic connectedness appear as significant factors in recovery.

Being part of a church community could potentially help with a sense of purpose and meaning. Philips and Ano (2015, p.308) "support theories concerning religious fundamentalism as a complete way of life, a means of providing structure, meaning, and other benefits to its followers." For fundamentalists, identity is pre-made, therefore the difficult and creative work of discovering one's likes and dislikes is often set aside in favour of obeying rules and regulations. Although this could be described as life-demeaning, it could also be experienced as an easy way to adopt a pre-formed identity, especially for those who have had traumatic experiences which impair their ability to make decisions. Nevertheless, the adoption of a pre-formed identity in fundamentalist communities means subservience to dogmatic leadership which is disempowering and fear inducing; therefore, this would not be an environment conducive to recovery.

Gschwandtner (2016) explains that in fundamentalist groups, fear is often at the root of the identity issues and drives members to adopt the identity of the group. Although the collective identity of fundamentalism may decrease fear around an uncertain personal identity, fear is increased as apparent threats from the outside world threaten the identity of the group. Drawing from research on the dynamic between society and self of fundamentalists, Herriot (2009, p.19) explains that "social constructs both create and are created by, the self." The bidirectional force of the social construction of identity is significant for both fundamentalists and those who experienced EDs. Healthy, life-giving church community can be conducive to the construction of a healthy identity which flourishes primarily through nurturance and love. However, in fundamentalist communities, identity often emerges through fear and shame and an unhealthy divisive relationship to the world outside that community.

5.3.5 Inhibited creativity

Relevance

My findings suggest that for those who experienced EDs, a variety of forms of creative expression appears to be therapeutic. There are at least two aspects that illustrate the importance of creativity: as a distraction from the ED and as an expression of emotion. The effects of disembodiment including dissociative tendencies appear to be linked to low creative capacity for the majority of interviewees who experienced EDs.

Response

The closed-mindedness of fundamentalism is widely recognised as an area that affects creative endeavours negatively. El-Haq, Abdelaziz and Mohamed (2016, p.163) suggest that this is an underdeveloped area of research, as "most of the research has focused on the factors that positively impact individual creativity, where a few focused on the impediments or the factors that negatively impact creativity." Strozier (2017, p.4) explains that those in the grip of fundamentalist thought live in a world "in which empathy has been leached out and where humor, creativity, and wisdom are absent." Shame stifles the ability to be creative and are common to both those in fundamentalist movements and to all interviewees who experienced EDs. Thompson (in Moll, 2016, p.64) explains that "[t]he single most powerful thing that shame does is truncate our capacity to create."

The closed-mindedness of fundamentalism causes a decreased capacity for innovative thinking and reduced creativity. Owing to the inability to think for oneself, it is not surprising that there is a common link between following authoritarian-type leadership and the lack of creativity in both those involved in fundamentalism and those experiencing EDs (Rubinstein, 2003; El-Haq, Abdelaziz and Mohamed, 2016). Rubinstein (2003, p.702) states: "[a] variety of experimental evidence and theorizing supports the notion that there is a negative correlation between creativity and authoritarianism." Evidence suggests that personality types that are more authoritarian in style are more prone to resist novel and innovative interventions and be more drawn towards social conventions that favour tradition (Rubinstein, 2003; El-Haq, Abdelaziz and Mohamed, 2016). Given that fundamentalism and authoritarian leadership styles are often linked, this would suggest that fundamentalist communities would not encourage creative endeavour, nor provide an environment that would facilitate creative flourishing. Isherwood (2008, p.137) explains: "[we] are still not at home in our flesh and so we fail to live the radical co-creative and co-redemptive implications of that reality." What is clear is that creative endeavours are useful in recovery but are significantly hindered in fundamentalist communities.

Conclusion

Armstrong (2014, p.303) clarifies that fundamentalism "is rooted in fear – in the conviction that modern society is out to destroy not only their faith but also themselves and their entire way of life." Fear debilitates creativity, and when one's creative capacity is disabled, this has a significant effect on identity and one's capacity to form an individuated sense of self. Although the rigidity and discipline offered in fundamentalist communities can provide a form of pseudo-comfort, the high levels of fear, which are distinctive of both those involved in fundamentalist movements and those experiencing EDs, impede creative capacity (Strozier, 2017). Creative capacity is essential to human flourishing and important for the recovery of women experiencing EDs, therefore church communities that have a fundamentalist approach would be unlikely to care for these vulnerable women effectively. The following conversation synthesising pastoral care literature and my findings will help clarify what needs to be understood by the pastoral carer when caring for those experiencing EDs and the pastoral methods that could assist in this process.

5.4 The research findings and the existing literature on pastoral care

There is little contemporary Christian pastoral care literature which focuses specifically on care for those experiencing EDs. Therefore, this conversation will integrate relevant pastoral care literature, other theological literature and relevant secular literature with my findings. This section will be framed in two parts: first, understanding the background and difficulties of those experiencing EDs, which is crucial for knowing how to respond and how to manage difficulties which may be encountered in pastoral care circumstances; second, specific practices in pastoral care that are identified as potentially helpful. The outline of these discussions is listed below.

5.4.1 Issues significant to women experiencing EDs that are relevant to pastoral care:

1. Managing distressing emotions
2. Understanding the effects of trauma
3. Identifying interpersonal issues

5.4.2 Significant practices for good pastoral care:

1. Listening
2. The restoration of identity
3. Addressing worthlessness and voicelessness

5.4.1 Issues significant to women experiencing EDs that are relevant to pastoral care:

5.4.1.1Managing distressing emotions

Anger, self-hatred and shame

Relevance

Anger is a dominant emotion in all of those who experienced EDs. It is most often internalised and subsequently contributes to feelings of self-hatred and shame. Three-quarters of these women suggest that body-related comments from others were a particular trigger for these emotions and the majority of those who experienced EDs refer to the fear of expressing their anger in case this displeases others and in turn makes others angry.

Response

As discussed on p.61, Harrison explains (2006) anger signifies that all is not well in our relation to other persons or groups. If emotions such as anger are suppressed, Lester (2003) contends that the intensity can combust destructively and further compound feelings of guilt and shame, fortifying the view that anger is wrong. For almost all of those who experienced EDs, self-destructive thoughts and blaming behaviour both of oneself and of others is a frequent outworking of anger. Conversely, Lester (2003, p.13) emphasises that anger is part of the created order and is a necessary part of our embodied emotional lives and essential for human survival. Traditional perspectives on anger being viewed as sinful should be avoided in pastoral care circumstances when caring for those experiencing EDs as this will inevitably increase their feelings of shame and worthlessness. As discussed on pp.61-62 Pattison (2007), Lyall (2001), Whitehead (2010) and Lester (2003) support the perspective that contemporary theology must avoid treating anger as sinful, rather it is necessary to embrace the reality of full emotional lives of individuals without condemnation or judgmentalism. In light of the fact that many of the women who experienced EDs have been abused, coerced and manipulated, anger is a healthy and appropriate response and should be encouraged and guided by biblical precepts rather than dismissed as inappropriately sinful.

Fear, despair and distress

Relevance

Intense fear and anxiety were common to all of the women who experienced EDs, and reports of feeling frozen in fear were common. Fear of being judged, combined with the fear and distress of letting others down, is evident throughout all of the interviews with those who experienced EDs.

Response

As Rambo (2009) explains, if the pain is overwhelming, there may be a total disconnect between experience and present emotion which causes a freeze response; this is often associated with extreme terror. Van der Kolk (2014) argues that this over-sensitivity is due to fear conditioning, which can be triggered by simple events that stimulate a memory of past trauma. Doehring (2015) and Whitehead (2010) explain that the natural neurological

response of fear is an automatic reaction to threat in order to inspire survival; however, the difficulty occurs when the fear persists long after the threat no longer exists. It is important for those embarking on pastoral care with those who experience EDs to understand reactivity and sensitivity to threat, as their apparent overreaction to somewhat normal circumstances can be understood as an effect of their traumatic past. Van der Kolk (2014) explains that in order to integrate traumatic experiences and navigate through these feelings of intense and seemingly irrational fears, support is imperative.

Despite the best intentions of carers, almost all carers admitted that they also felt intense fear, loneliness and helplessness in their efforts to care. The transference of fear from carers to the individual experiencing the ED is a bidirectional force and may feature as part of prolonging the illness. These factors evidently point to a crucial need for support in pastoral care and counselling, not only for the individuals experiencing the ED, but also their families.

Emotions and recovery

Relevance

Approximately half of the interviewees who experienced EDs, being almost all of those who spoke of their recovery, commented on a curious increase in painful emotions and distressing thoughts during recovery. Increased awareness of, and the ability to notice and feel, their emotions were particularly relevant for these women.

Response

As discussed on p.62 Nouwen (1977) explains that pastoral care should deepen rather than avoid one's pain. Almost all of the women who spoke of recovery also commented on feeling as if they have an ability to tolerate distress and experience emotions rather than trying to avoid them. Kalsched (2013) powerfully describes the nature of therapeutic rapport by using Dante's relationship with Virgil in "The Inferno." When traumatic experiences are left unresolved, the difficulties in emotional connection are often reported to cause a profound breakdown of connection in relationships and thus further compound the impact of the trauma (van der Kolk, 2014). During recovery, at least one stable relationship was important for all who spoke of recovery as they navigated through their emotional anguish. However, for the inexperienced and unwise pastoral carer, accompanying the one who is suffering

through these explorations could be frightening and therefore efforts to shut down emotional expression could appear to be the most comfortable option. Nevertheless, both my findings and existing literature support that feeling the pain is a necessary stage on the journey from emotional trauma and it must not be rushed or avoided as it is often the first sign of a significant thawing of emotional numbness (Rothschild, 2004).

5.4.1.2 Understanding the effects of trauma

Trauma and shame

Relevance

Approximately two-thirds of those interviewed who experienced EDs reported childhood or adolescent trauma in verbal, physical or sexual forms. For approximately half of those who speak of traumatic experiences, it appears that these experiences were not isolated; rather, trauma was repeatedly experienced in different circumstances often causing immense feelings of shame.

Response

As complex and simple post-traumatic stress can be caused by emotional, physical or sexual abuse resulting in unbearable anxiety and fear (Hunsinger, 2015) it is therefore not surprising that those who disclosed sexual abuse referred to a sense of disgust, internalised anger and shame. Van der Kolk (2014, p.97) explains that "[t]raumatized people chronically feel unsafe inside their bodies: The past is alive in the form of gnawing interior discomfort." Furthermore, Beste (2007) contends that trauma is often so terrifying that it threatens one's psychological integrity; when integrity dissolves, what is left is often a deep sense of shame and fear. This theme correlates with Kalsched's (2013) interpretation of early relational trauma, which is particularly acute in early years when experiences are too much to bear consciously. Understanding the failure to integrate the devastating effects of childhood trauma is crucial to understanding the emotional and behavioural implications after the event and holds valuable insight into how to care for individuals who have had such experiences.

Van der Kolk (2014) suggests that repetitive reenactment and revictimisation are common in those who have experienced trauma, which is also associated with self-harming behaviour.

Van der Kolk explains that although repetitive reenactment further fragments the psyche in the lives of those who have been violated, stopping the cycle is possible with a therapeutic relationship which makes these women particularly vulnerable. Shooter (2016) effectively describes the fragmentation from self, God and others combined with a deep sense of shame when one has been the victim of abuse. Pattison (2000, p.296) explains that the "aim of Christian practice … is to help overcome alienation and exclusion. This might help enable shamed people and groups to see themselves, others, and God, face to face." Although the reenactment of trauma is a frequent occurrence in those who have been violated, awareness can emerge through a therapeutic relationship, and patterns can be noticed and subsequently changed. The loneliness of feeling emotionally ostracised can thus be overcome, and with healthy relationships, a sense of equality can emerge. Effective pastoral care has potential to function as the catalyst for this change.

Repression of memories and finding a voice

Relevance

Almost three-quarters of those who experienced EDs reported immense difficulty in breaking the silence and recalling traumatic memories. In association with the inability to put words to the experiences, almost all of the women who experienced EDs reported feelings of emotional numbness.

Response

As Rambo (2009) explains often the force of a traumatic experience can disempower to the extent that one's voice is debilitated, and it becomes extremely difficult to construct a coherent narrative to describe the experience. Tillich (1963, p.28) indicates that often, "situations have a voiceless voice." Trauma specialists such as Herman (1992), van der Kolk (2012) and Rothschild (2004) emphasise that sometimes individuals who have experienced trauma cannot voice their needs using human language. It is vital, therefore, that the pastoral carer or counsellor should draw upon his or her experiences, knowledge and skills to listen and hear well. As noted on p.24, Herman (1992) explains the danger of recalling memories and, like Rothschild (2004), emphasises the necessity of being equipped to skilfully and therapeutically handle flashbacks and nightmares. Ensuring safety when considering the pain encountered in recalling memories is of the utmost importance in pastoral care. Rothschild

(2004), emphasises the necessity of knowing that one's client can "find the brakes" before recalling traumatic memories.

Dissociation and disembodiment

Relevance

The majority of those who repeatedly referred to feelings of disembodiment, dissociation and emotional numbness of dissociation also commented on significant trauma in their past. Similarly, nearly all of the carers noted emotionless detachment at different stages along their loved one's journey.

Response

Dissociation is an adaptive response to an external stimulus which often prompts feelings of intense fear and is most common in those who have experienced trauma (van der Kolk, 2014). Although numbing emotions may provide temporary relief, the full spectrum of emotional experience is essential in connecting the mind and body and vital in living a healthy life (Doehring, 2014). This experience of mind-body splitting is common to all who experience EDs (Granieri and Schimmenti, 2014). As discussed on pp.23-24, although dissociation is often thought to be a dysfunctional and disordered mechanism of the psyche, it in fact serves the function of preventing the psyche from shattering when unbearable trauma is experienced or remembered. Although 'splitting' through dissociation is crucial in survival, it has an extremely adverse effect on one's capacity to enjoy life (van der Kolk, 2014) and as supported by Kenny (2015), the duality of body and mind causes identity confusion. The false self (Winnicott, 1965) and malevolent archetypal figure (Kalsched, 2013) could be understood as the ED voice, which is often described as an entity in itself. Integration of the false and true self should be the aim of pastoral care as this lack of integration is at the root of the split between the body and the mind. The psychological process of integration parallels the theological process of "witnessing" (Rambo, 2010, p.42). Rambo (2010) points to the possibility of trauma as being crucial to a theology of redemption rather than a confrontation to our theological understandings or a difficulty that theology must navigate. Rambo (2010, p.150) explains the concept of witnessing through pointing towards the need humans have to understand their lives through understanding and telling their story, therefore they need a beginning, middle, and end to facilitate the "practice of attention" which is the essence of

being a witness to trauma. In order to care skilfully for those who have experienced EDs, an understanding of mind-body integration is essential, alongside an understanding of the theological relevance of trauma (Rambo, 2010; Kalsched, 2013; Doehring, 2015).

5.4.1.3 Identifying interpersonal issues

The personification of the ED

Relevance

In the majority of the interviews, two voices are often talked about: the voice of the ED and that of the woman experiencing the ED. This relentless inner battle is common to all interviewees who experienced EDs and most commonly it is this aspect of the disorder that both carers and those with insight found frightening.

Response

As noted on p.27 when the splitting of the psyche occurs as the result of unbearable trauma and inadequate nurturing, the 'false self' and 'true self' emerge (Winnicott, 1965). Kalsched (2013, p.11) explains: "the progressed part [the false self] might appear as a sadistic, tyrannical figure, attacking or imprisoning the child [the true self] … or as a 'false god,' part of the narcissistic defensive system." As self-denigrating self-talk and the propensity to punish and abuse oneself are particularly prevalent, the ED voice reflects the "sadistic, tyrannical figure" as described by Kalsched (2013). Supported by Kalsched's interpretation of Jung's archetypal universal images, the attack appears to be focused on the annihilation of the true self. Kalsched (2013) emphasises that, for integration to occur, the voice of the false self must be heard alongside the voice of the true self, as the individual who is suffering needs to be treated as a cohesive whole, otherwise further fragmentation occurs. To care pastorally for those experiencing an ED, the presence of the ED voice must be accepted, acknowledged and understood.

Creativity and relationships

Relevance

Creativity is a significant part of recovery for approximately three-quarters of the women who experienced EDs. There are at least two aspects that illustrate the importance of creativity: a distraction from the ED and an expression of emotion.

Response

When trauma occurs the mind and body is often shut down to creative processes and rigidity and rule-following becomes the method of everyday functioning. However, when one moves further towards embodiment and functioning as an integrated human being, the transitional space is opened which permits access to the imagination (Winnicott, 1971). Kalsched (2013) is adamant that the quality of the therapeutic relationship itself is of paramount importance in opening this space. He (2013, pp.19-20) explains that "[s]uch a relationship holds the hope that both inner and outer transitional space may open once again, that connections in the brain can be slowly re-wired, and that archetypal defenses will release us into human inter-subjectivity and ensouled living." When the transitional space (Winnicott, 1971) is open, this provides a pathway for creativity and play for the good use of the imagination. In this transitional space one moves from the internally constructed world of fantasy to the outer world of reality. Van der Kolk (2002) explains that the creative use of the imagination in looking forward to future possibilities, rather than repeatedly retelling the past, is an integral part of healing from trauma. As trauma bears its mark on the entire body Rambo (2010, p.73) explains "Meaning is dead. Hope is dead. Love is dead". The bridge of imagination to future possibilities has disintegrated. The interruption of time caused by the memory of the past trauma and its subsequent impact on the future is reminiscent of the time disorientation illustrated in St. John of the Cross' 'The Dark Night of the Soul '(Kavanaugh & Rodríguez, 1979). As discussed on p.99, Moltmann (1994) further proposes that hope in unseen possibilities reflects the creative act of God through the resurrection of Christ. Moltmann (1967, 1971, 1975) emphasises that this is not merely a matter of historical reference nor a point of reference to a future hope, but rather an opportunity for participation in a life-giving force and healing in the here and now. Hope is symbiotically linked with the imagination and is a necessary component to healing and spiritual formation (Ursic, 2017; Smith, 2013).

5.4.2 Significant practices for good pastoral care

5.4.2.1 Listening

Relevance

Half of those who experienced EDs also recalled unhelpful and anger-inducing encounters with people who wanted to 'fix' them. All who spoke of repeated relapses and a lack of recovery consistently recalled not feeling adequately understood and feeling rushed to recover faster. For all of those who experienced EDs, trust appears to be synonymous with compassion and is essential to feeling safe enough to share their story.

Response

Osmer's (2008) emphasis on priestly listening to ascertain "what is going on?" is of the utmost importance in the pastoral care of those experiencing EDs as such individuals often believe that "no one is listening" (Kalsched, 2014, p.3). As discussed on p.65 Tillich (1963, p.28) explains the phrase "listening love" as that which requires a surrender of efforts to control, manipulate or pre-determine the pathway taken by the client in responding to his or her difficulty. As discussed on p.24 trauma specialists affirm that deliberately slowing down the process of recovery is often necessary for those who have experienced trauma. Herman (1997) believes that, because trauma involves a fundamental violation of trust, it is only through the restoring power of truly gracious loving relationships that healing becomes possible. Kalsched (2013, p.13) affirms "what has been broken relationally must be repaired relationally." The ability to empathise without bringing one's issues and pre-judgement into the room are often referred to as 'congruence' in counselling, interpreted as a measure of authenticity and genuineness. Rogers (1951) believes empathy, non-judgment and fundamental acceptance, irrespective of behaviour, are essential in a therapeutic relationship. In light of this, there must be carefulness in how God is presented in pastoral care, God must be presented as being aligned with the suffering, sick and sinful aspects of human experience rather than sitting as an absolute judge, concerned only with punitive justice.

Doehring (2014, p.585) warns of the existence of some areas of unskillfulness in prevailing methods of pastoral counselling; she explains, "[t]hey seek to explore what's going on below

the surface emotionally and assume that emotional catharsis is the key to change." Unlike this pervasive psychological theory of change, trauma specialists such as Herman, Rothschild and van der Kolk suggest that slowly helping the person who is suffering to connect with their body, rather than divulge all their emotions in narrative form, is the key to healthy recovery. Levine (1997) asserts that as the sense of security in one's body develops, that the capacity to form relationships increases and the heightened reactivity to perceived threat decreases. Therefore, safety and non-judgmentalism are of the utmost importance, particularly in the therapeutic relationship. Pastoral carers must, therefore, be particularly aware of the need for vigilance in confidentiality, non-judgmentalism and stability to facilitate the safe recovery of those experiencing EDs in order to increase their aptitude to form healthy relationships. The Aristotelian concept of *habitus* as discussed on p.69 is prescribed by Osmer (2008), Smith (2013), and MacIntyre (1981) as vital in spiritual formation. *Habitus* emphasises that influencing somatically-based practices, as opposed to cognition, are the priority, and therefore should become the focus of pastoral care for those seeking recovery from EDs.

5.4.2.2 The restoration of identity

For almost all of those who have experienced EDs, interpersonal disconnection through isolation combined with a low ability to feel self-compassion or love is a constant feature. For approximately half of those claiming insight, there seems to be an understanding of the rigidity involved in EDs which makes issues of identity difficult and the prospect of change, at times, unbearable.

Response

The collective characteristics of the interviewees who experienced EDs correlate with insecure attachment styles, which has a direct impact on perceptions of God's security, availability and dependability (Homan and Boyatzis, 2010; Homan and Cavanaugh, 2013; Strenger, Schnitker and Felke, 2016). This insecurity often leads to doubting the trustworthiness of God, avoiding being identified with or having intimacy with Him because of the subsequent psychological distress of being rejected by Him. As discussed on p.64, Miller-McLemore (2005) suggests that context is integrally important to understanding living human documents in that interpersonal connections, in the form of relationships, are

essential to understanding one's identity. Osmer (2008) believes that the practices and relationships embodied by church community shape one's identity. Therefore, the practices inclusive in church communities should be shared Christian praxis (Campbell, 1981), embodied by the entire community and based on forming healthy, loving relationships. Lartey (1996) maintains that the task of pastoral care is to recognise the 'social phenomenon' of love which brings individuals into a relationship with God and others.

Doehring (2015) explains that as spiritual practices encourage self-compassion, this can help engulf the torturous feelings of shame and give meaning to one's life as part of the wider Christian story. Encouragement, not condemnation, is an important practice in all those who seek to offer care to those experiencing EDs. Cooper-White (2012) claims that through retelling one's story in a safe, non-judgmental space, what was once unbearable becomes bearable and God's compassion is channelled through the pastoral carer. Given that self-imposed social isolation is common to all who have experienced EDs, pastoral carers should give particular importance to compassion, as demonstrated through action. This is an essential part of Christian pastoral care, being described by those claiming insight definitively as "the heart of the gospel."

5.4.2.3 Addressing worthlessness and voicelessness

Response

Low self-esteem and feelings of worthlessness feature in all of the interviews with women who experienced EDs. For almost all of them, subservience and the inability to find their voice during the most intense stages of the ED are connected to a low ability to trust oneself.

Relevance

The restriction of speech, whether through an inability to remember or through having no one to listen, often results in a profound breakdown of connection between persons along with an inability to sustain relationships. Rambo (2009, p.237) explains:

> Traumatic events challenge one's ability to apply cognition and words to describe what took place and to create a coherent narrative out of chaos. The emphasis on recovering a narrative of the traumatic event responds to this isolation and pain, resulting from not having a language to identify an

> experience. Barring access to speech – and communication more generally – is a means for taking away someone's power.

Even when words can be found to describe the experience, they are often ineffective in the attempt to integrate the disorganised sensations and consequential behaviours which are perpetrated by the imprint of the trauma. Caruth (1996, p.4) argues that "trauma seems to be much more than a pathology, or the simple illness of a wounded psyche: it is always the story of a wound that cries out, that addresses us in the attempt to tell us of a reality or truth that is not otherwise available." In order to facilitate an environment for recovery it is vital that Christian pastoral care be consistent, non-judgmental and be the entrance point for safe exploration and discovery

Hunsinger (1995) suggests that the pastoral counsellor can become an image of a trustworthy 'good object' to whom a woman can speak and voice her needs and feel heard. This image can serve as a reflection of the trustworthiness of God and the embodiment of selfless love thereby cultivating a safe environment to form a healthy attachment (Hall and Maltby in Bland and Strawn, 2014). Pastoral care must emphasise the need for a delicate balance of encouraging self-efficacy and room to grow, while also ensuring the safety of the individual. Just as encouragement towards self-actualisation and individuation is an important part of human flourishing, the interchange which occurs in church communities is reflected by what MacIntyre (2002, p.81) describes as "the networks of giving and receiving." Thus, flourishing and movement towards being what MacIntyre (2002, p.81) describes as an "independent practical reasoner" and an individual in one's own right, are essentially dependent on relationships in which one can receive and give love. In light of the isolation, individualism and lack of trust exhibited by those experiencing EDs, communicating and modelling the appropriateness of natural human dependence is an important part of care, and therefore, modelling safety and the possibility for nurturance through discipleship in community is vitally important as a practice of pastoral care.

Empowering the submissive

Relevance

Approximately three-quarters of all of those interviewed mentioned the imbalance of power in relationship to gender within church communities and commented that this might prove a

difficulty in pastoral care for women experiencing EDs. With regard to the issues of personal faith, those who experienced EDs offer mixed views on the perspective of God being in control, with approximately a third finding this more of a disempowering factor, underpinned by feelings of worthlessness and not being good enough to come to God.

Response

In a reflection of the suffering and subsequent insight experienced through Boisen's (1971) emotional breakdown, Miller-McLemore (in Moessner, 1996) emphasises the need to listen to the voices of those who have felt ostracised and marginalised through mental illness. Miller-McLemore (in Dykstra, 2005) emphasises that feminists promote the necessity of emotional expression in women in response to varying forms of male-dominated oppression. As discussed on p.102, Keller (1986) reflects on the disempowerment of women as part of Western society's patriarchal heritage and affirms that in contemporary society the empowerment of women is of the utmost importance. The exploration into the causes of feelings of inferiority and excessive fear is an important task for the skilled pastoral counsellor, and a crucial part of the rehabilitation of women experiencing EDs.

Pattison (2000) explains that a presentation of an all-powerful God may not be the most fitting image to present to one who is feeling deep shame. He (2000, p.241) explains that those who are tormented by shame "may be encouraged to see themselves as bad, powerless, defiled and unworthy before the face of an all-good creator." In pastoral care there ought to be a divestment of power, however, as Doehring (2015) explains, there is always a power dynamic in caregiving relationships which is not necessarily negative; rather love can be evidenced through appropriate exercise of power. *Agape* one of the New Testament words translated into English as the single word 'love,' might be defined as the exercise of one's power for the good of the loved one. Tillich (Nesbitt, 1957, p.50) claims that when one encounters and participates in the life of the other person, one accepts his own particularities, the characteristics of which constitute his personality and believes agape is correctly defined as "acceptance of the other self by participating in his personal centre". In Dohering's (2015, p.45) explanation of "agential and receptive power" in pastoral care, she is clear that this dynamic can, in itself, be therapeutic. Feminist theologians agree that patriarchy and male dominance is still an issue in many church communities, and seek to

challenge this, as it is destructive to human flourishing and pastoral care (Glaz and Moessner, 1991; Isherwood, 2008).

Conclusion

Sometimes people who have experienced trauma cannot voice their needs using human language; therefore, the pastoral counsellor must draw upon his or her experiences, knowledge and skills in order to authentically listen. The requirements of obedience to the existential nature of theology are embodied in *habitus* wherein right practice and wisdom reside. It can bridge the gap between theory and practice. This is especially relevant in some communities as there is evidence of a significant gap between a desire to present God in a manner which is seen as 'biblical' and the care of the help-seeking individual. Therefore, in light of these findings, women who have experienced EDs must be recognised as marginalised individuals and given a space in which to speak and time to be heard from within their own contexts, before integration within a church community becomes a possibility. In the following chapter I will offer guidance concerning how the Church might practically and pastorally respond to the synthesis of the findings and existing literature on EDs, fundamentalism and pastoral care.

5.5 The research findings and the existing literature from feminist theology

As feminist theologians challenge conventional male-orientated perspectives pertaining to human flourishing and practical care, their work will engage with an analysis of the empirical findings in order to help clarify which characteristics in pastoral care need to change to better care for those experiencing EDs. A feminist critique of church communities suggests that fundamentalist-like caregivers can have an unhelpful approach to pastoral care despite their theological expertise and good intentions, by misinterpretation and through unhelpfully imposing rational logic onto the practices of persons and communities. Miller-McLemore (in Dykstra, 2005, p.42) writes: "[a] feminist perspective demands an analysis of structures and ideologies that rank people as inferior or superior according to various traits of human nature, whether gender, sexual orientation, colour, age, physical ability, and so forth." Feminists are universally recognised for their insistence that women need to find their voice and own their right to be viewed as equal value to men, therefore when interacting with the voices of women who have experienced EDs there is evidence of significant chasm which needs to be bridged. As feminist pastoral theologians challenge regimes of power and male-orientated approaches to care, contextual objectives that value women's insight, experiences and perspectives on care as both care receivers and caregivers emerge and will be important in forming recommendations in Chapter Six. Through critically analysing the research findings and the existing literature from feminist theology, this section will demonstrate how a selection of feminist theological insights can positively shape discussions on pastoral care and frame the place of religion and spirituality in recovery from EDs. This section illustrates the crucial place of theology in deriving an appropriate response to the situation outlined and analysis so far and moving towards more concrete recommendations in Chapter Six. The themes below were particularly significant in my findings and particularly relevant to the discussion on how to provide appropriate care in church communities. The most salient of these these will be further explored in Chapter Six.

1. Dualism and disconnection — Feminist views on Theological anthropology, Christology and embodiment

2. Emotional distress — Feminist views on Theological anthropology and vulnerability

3. Isolation — Feminist views on theological anthropology and intimacy

4. Shame — Feminist views on Christology and shame

5. Compassion — Feminist views on Christology and relationship

6. Control and Power — Feminist ecclesiology and negative church-based experiences

7. Views on the church/statutory care as supportive to recovery — Feminist ecclesiology and community, Feminist ecclesiology and negative church-based experiences

5.5.1 Dualism and disconnection — Feminist Theological Anthropology and Christology

Christology and embodiment

Relevance

Distrust and hatred of one's body were common to approximately three-quarters of the interviewees who experienced EDs. Almost all refer to being emotionally numb and the majority comment on feelings of being disconnected from their body. The experience of mind-body splitting was common to all interviewees who experience EDs and was amplified in those who exhibited strongest traits of self-objectification.

Response

As the Christian Church is defined as (among other things) the body of Christ which is united by Christ as its head and celebrates the diversity of its members, this must have a direct and indisputable effect on the manner in which one's body is also viewed. Such body symbolism is of particular importance for a feminist critique, as Church tradition has often identified women with bodiliness and declared such bodiliness impure and defiling. For many Christians there is a significant overemphasis on the divinity of Christ over His earthly nature; from this perspective a sense of detachment from both the world and disregard for one's body can emerge and can, for some, increase a sense of longing for heaven and a disregard for the reality and joy in earthly interactions. For the reality of the victory narratives of the biblical text, hymns and prayers to be a lived reality, Christ's immanence must be understood as an embodied human being, while it is also vital to experience the transcendence through a

realisation of the redemptive thus liberating power of Christ. Incarnation is central to Christian belief but, paradoxically, this doctrine has not traditionally encouraged a positive theology of the body. As the redemption of Christ through His body is the key to the biblical narrative and the crux of the incarnation, this fundamental factor must have a place in looking at the body as a site of liberation rather than imprisonment, as an embodied incarnation. Feminist theologians (Isherwood, 2002; Heyward, 1982; Brock, 2008) emphasise that disembodiment originates from the damaging effects of dualism which is deeply embedded in the Christian tradition. They suggest that this kind of thinking has distanced humanity from themselves, others and God and furthermore marginalised and oppressed the vulnerable, they declare this must be rectified through new theologies of embodiment. A sense of disconnection from God and Jesus and an inability to sense Him as close or see usefulness in His being close was common for almost all of those who experienced EDs. This could be related to an inability to comprehend the humanity of Christ in God. Again, Heyward (1982, p.xix) explains that we must take our human experience seriously: "[w]e are left alone untouched until we choose to take ourselves - our humanity - more seriously than we have taken our God."

According to Day, (1992, p.15) "The ultimate basis of a secure and healthy sense of self-worth is directly related to the level of accepting, understanding, and experiencing the truth of our being image-bearers of God." This body-based emphasis is further explored on p.207 and is particularly important for those experiencing EDs as feelings of low self-worth are amplified by the self-hatred and attacks upon one's body which exemplify the dissonance between body and mind. For many women experiencing EDs, the 'perfect' body is desired and seen as a means by which she gains respect; consequently, this externalisation results in objectification as described on p.162. An emphasis on reason in the substantive approach has an important place when considering the reflection of those experiencing EDs as made in the imago Dei. However, true wholeness cannot be established without an emphasis on the importance of embodiment as a key protective factor in ensuring that the body is not dualistically viewed as an being controlled by the mind and rather the intrinsic worth of the body is viewed as equally important.

As a sense of worthlessness and torment over imperfection were the most commonly commented on by those experiencing EDs, an affirming anthropology for women is essential if Christianity is to be influential in the recovery of those experiencing EDs. As the theological concept of the *Imago Dei* declares that men and women are created in the image and likeness of God, this theological principle establishes and emphasises the dignity, equality, and mutuality of men and women. Given that difficulties regarding self-image are a significant factor for all experiencing EDs, the feminist emphasis on equality in the *Imago Dei* is a lynchpin to theologically based equality in the church and society.

Voice

Relevance

The relevance of this issue is apparent as almost all of the women who experienced EDs expressed that the inability to voice their needs was linked to a propensity to be subservient, submissive and to please others before themselves. The consensus of almost all of them is that this lack of control leads to internal oppression and a sense of being imprisoned in one's body. As an integral part of recovery, finding one's voice is a crucial part of rehabilitation and an appropriate sense of embodiment leads to women being able to say, "I am worth listening to."

Response

By failing to affirm incarnate worldly experience and rather by attempting to escape from or deny it, fundamentalist-like theology encourages a hostile disconnect from one's body and everyday worldly experience, therefore, causing a consequent disembodied form of spirituality. Alternatively, If the resurrection of Jesus Christ is viewed as an essentially bodily reality, this becomes a living denial of dualism and therefore a monumental place of hope. An embodied resurrection provides the possibility of possessing Christian hope through Christ's physical presence. Consequently, the resurrection becomes relational and personal. This hope can, therefore, help those experiencing EDs to see their circumstances more as regards to the possibilities and potential and recognising, as Moltmann (1967) suggests, that hope need not be inherent in the actual situation in which one finds oneself, but instead is founded on the nature of the resurrection. Through women's bodies, the flesh needs to find

words and a voice that has been silenced in male-dominated Christian theology. A focus on the fleshly nature of the incarnation enables women to find a voice and to make their desires known; this experience is inherently linked to erotic power which helps humans to embrace the experience, openly and fearlessly, with intense joy (Rivera, 2015).

5.5.2 Emotional distress — Feminist views on Theological anthropology and vulnerability

Vulnerability and oppression

Relevance

For almost all of the women interviewed, pleasing others is connected to submissive behaviour and subservience, which is significantly damaging for women experiencing EDs. Furthermore, almost half of those who experienced EDs reflected upon negative experiences of being vulnerable before God and compared it to surrendering power through subservience to 'abusive others' in their lives, therefore this adds complexity to the issue of intimacy with God.

Response

Although androcentrism is not, by necessity, always part of complementarian thinking, subliminally patriarchal agendas are often played out through this approach. The method of gender complementarity in fundamentalist-like contexts, which includes Roman Catholic and newer churches, subjugates women to the role of "passive" helper to men and reduces their social function to reproducer and aide. Although paternalism is viewed by many feminists as locked into traditional Christianity, care for the vulnerable is at the centre of Israel's covenantal language and Jesus' ministry. However, given feminist perspectives on the patriarchal, androcentric, and ethnocentric leanings of traditional Christianity, this appears more theoretical than actual in many fundamentalist-like church communities in NI. Nevertheless, there is a theological perspective that suggests that radical equality is at least arguable in the OT (I Sam 7:12; Ps 121:1–2). Many feminist theologians suggest that although power and boundaries are a necessary part of church hierarchy and structure, this should not be oppressive and, indeed, that oppressive power dynamics are exposed as entirely non-reflective of both Old and New Testament directives.

Rather than viewing women as the ostracised group, Miller-McLemore (in Dykstra, 2005) emphasises that feminists promote the necessity of emotional expression in women in response to varying forms of male-dominated oppression. In a reflection of the suffering and subsequent insight experienced through Boisen's (1971) emotional breakdown, Miller-McLemore (in Moessner, 1996) emphasises the need to listen to the voices of those who have felt ostracised and marginalised through mental illness which is linked to EDs. This must impact the practice of pastoral care and will be expanded upon in Chapter Six.

Vulnerability and creativity

Relevance

For approximately half of those who experienced EDs, there is notable anger and a sense of hurt when speaking of religion, church and God, in contrast to other parts of their transcripts. Creativity is a significant part of recovery for approximately three-quarters of the women who experienced EDs.

Response

As invulnerability points to being closed to change and challenge, thereby also inhibiting innovation, this rigidity was common to all those who experienced EDs. Creativity and responsibility originate in the courage to accept the natural vulnerability in what it is to be human, as that condition of potential from which both the positive and the negative emerges. Brock (2008, p.17) claims, "To be born so open to the presence of others in the world gives us the enormous, creative capacity to make life whole. Yet such openness means that the terrifying and destructive factors of life are also taken into the self, a self that then requires loving presence to be restored to grace." Love, forgiveness and realisation of boundaries as ingredients for a mutual/right relationship are closely intertwined with vulnerability and are experienced in the erotic life of human beings in which lies "the primary wellspring of our capacity to be creative together" (Heyward, 1980, p.27)**.** The Christian imagination can offer hope even in the midst of brokenness and suffering and can free those who are hurting, offering new possibilities and potential. Ursic (2017, p.325) explains: "[w]e are called to be a prophetic witness of what lies just beyond what is known and bring it into awareness, not just for ourselves, but also for others through our writings and artistic expression." Prophetic

witness requires the fluidity of creative imagination; as discussed on p.32, Cook (2004, p.548) indicates that creativity is integral to spirituality and an essential part of human experience. When oppressive, non-creative forms of leadership dictate the life trajectories of the vulnerable, this eclipses the freedom, creative potential and transformative power of the Holy Spirit.

Fear and creativity

Relevance

In the interviews with women who experienced EDs, it is evident that fear and anger arrests their rational cognition in a manner which closes down their capacity to be vulnerable and instead puts barriers in place to protect against perceived danger. Therefore, neurotic fear must be reframed to experience intimacy with others and with the Divine.

As fear debilitates creativity, and when one's creative capacity is disabled, this has a significant effect on identity, ability to flourish and one's capacity to form an individuated sense of self. Although the rigidity and discipline experienced by those interviewed have provided a form of pseudo-comfort, the high levels of fear impede one's creative capacity to flourish. Creative capacity is essential to 'becoming', human flourishing and imperative for the recovery of women experiencing EDs. Approximately half of the carers seem to be aware of creative media as a part of recovery for their loved one. Alternatively, the stunting of creativity and the inability to play or find humour in life was referenced by both carers and those who experienced EDs as an integral component of the perpetuation of the disorder. Experiencing vulnerability opens the capacity to imagine and therefore provide a pathway to transformation and growth. Brock (p.36) suggests "Play links self and world. Through playing, the heart heals, connects, and creates. The relational play space itself is the locus of erotic power, as that space between the individual and his or her world." When considering that many individuals felt unable to engage with humour or play healthily through their levels of high anxiety, it is likely that being encouraged to play and laugh in a childlike manner could be liberating experiences.

To access the Christian imagination, feeling safe and free from oppression are crucial for those in recovery from EDs, this area will be further developed in Chapter Six. Furthermore, the

embodied practices of imagination help one to sense life in a manner which opens up the door to the fulfilment of the promise of God in the forthcoming redemption.

5.5.3 Isolation — Feminist views on theological anthropology and intimacy

Intimacy, relationships and vulnerability

Relevance

Those who experience EDs often disconnect from relationships, sensing that their behaviours may, at least temporarily, alleviate emotional pain, increase feelings of safety and decrease vulnerability and therefore decrease intimacy in relationships. The majority of those who have experienced EDs highlight that social interactions are highly problematic for them and by consequence often seek reassurance to cope when faced with interpersonal interaction.

Response

As personhood is inevitably linked to relationships, being a 'person', means not simply being 'oneself' but being in relationship-to-others, therefore how one views oneself has a distinctive impact on how one is in relationship to others. The divine incarnation and salvific power in human life, must reside in connectedness and not in single individuals (Brock, 1988; Heyward, 1989; Isherwood, 1998 and Moltmann-Wendall, 2001). Decisions and actions are not made by one person but result from historical circumstances and from our deep relatedness to other persons.

When Christian communities celebrate and embrace the differences in individuals, this impacts our Christian view of relationships, further permitting the individual who is in recovery to test boundaries without fear of retribution in a place of unconditional acceptance and love. As Christ enjoyed eating, drinking and friendship after his resurrection and before His ascension, this exemplifies the importance of community and intimacy in relationships to provide healing, forgiveness and empowerment. Post-resurrection is the critical location where hospitality is seen as the essence of the gospel narrative; this sits in contradistinction to the isolation and loneliness often experienced by those who were interviewed. By building a secure base, church communities can provide an optimum environment to cultivate erotic power, protection and safe boundaries. Therefore, a community environment that promotes erotic power through a sense of interconnectedness could provide the optimum healing

environment to cultivate a more secure sense of self. We will look at this in practical terms in Chapter Six.

Vulnerability is akin to receptivity, which points to the ability to be touched, interrupted, challenged, and even changed and transformed. Intimacy is not possible without vulnerability; it is a capacity that marks the human condition: all human beings are vulnerable. Because of this primary characteristic we are physical and social beings capable of interaction and responsibility. In this reading, vulnerability becomes the fundamental condition of reciprocity and intimacy. As those experiencing EDs accept the reality of and become more comfortable with their vulnerability as the universal human capacity to be affected and affect, their sense of erotic power and the interconnectedness of all humanity will increase, and feelings of isolation and loneliness will begin to dissolve.

Power and intimacy

Relevance

Over half of those who experienced EDs also referred to the ED itself as a controlling and demanding relationship. For almost all of those who experienced EDs and spoke of recovery, connecting with others in safe, trusting relationships has been a vital component in recovery.

Response

McFague (1993, p.159) recognises the need to overcome the male-centered God model. She suggests metaphors of God as a mother, a lover, a friend, and "the world as God's body". Reuther (1983) suggests an inclusive God/ess model, which includes metaphors for both women and men. She (1983, p.93) explains, "Christian theological anthropology recognises a dual structure in its understanding of humanity.... The question for feminist theology is how this theological dualism of imago Dei/fallen Adam connects with sexual duality, or humanity as male and female." Ruether (1983, p.93) further asserts that the tendency has been "to correlate femaleness with the lower part of the human nature in a hierarchical scheme of mind over body, reason over passions" (Ruether, 1983, p.93). Ruether therefore calls for a languaging of the *imago Dei* as based in women's experience and posits that divine languages are needed which safeguard women from subordination to male domination, but instead

could eventually open up the possibility for a renewed community, liberating humanity from the ground up. This is of much importance when considering those experiencing EDs' capacity to understand who God is, who God has made us to be and who God desires that we become (2 Corinthians 3:13, Romans 8:29, Colossians 3:10) Therefore it is imperative that those experiencing EDs are aware that being human is not simply one's created nature in an individualistic sense, it is also the experience of loving and being loved in relationships. According to Kilby (2000, p.436) "Because feminism identifies interrelatedness and mutuality - equal, respectful, and nurturing relationships - as the basis of the world as it really is and as it ought to be, we can find no better understanding and image of the Divine than that of the perfect and open relationships of love." Considering that for many feminist theologians the starting point for theological anthropology of the *imago Dei* is women's experience in relationship, this amplifies the necessity of communion in community. This category of woman's experience in theology emphasizes the importance of "the flourishing and full humanity of women" (Thompson, 1995, p.23) which develops the connection between *imago Dei* and *imago Christi* and the full humanity and thus equality of women in mutual relationships.

Feminist theology is progressive in its definition of power. It is often viewed as a mutual interchange of influence, an ebb and flow of agential power which guides and influences, takes in and receives. In pastoral care there ought to be a divestment of power, however, as Doehring (2015) explains, there is always a power dynamic in caregiving relationships which is not necessarily negative; instead, love can be evidenced through the appropriate exercise of power. Agape might be defined as the exercise of one's power for the good of the loved one. In Doehring's (2015, p.45) explanation of "agential and receptive power" in pastoral care, she is clear that this dynamic can, in itself, be therapeutic. The dynamic nature of relationships always has an aspect of power, but this need not be deemed oppressive in every circumstance, but instead many could be viewed in the context of covenants. As the interviews suggest, EDs have in some ways reflected girls' and women's lack of power to more directly control the objectification of their bodies and it is evident that power is a particularly poignant issue. When considering that the women I interviewed who experienced EDs were unable to exercise their power and also had difficulty in making decisions, therefore directive authoritarian relationships were not merely submitted to; it was often sought out and

desired. Jesus' ministry was based on intimacy, not on a lording of power or manipulation. This faculty of relation links to *dunamis* and erotic connection, and suggests that authentic empowerment comes through the realisation of and the connection with one's deepest passions (Isherwood, 2004; Heyward, 1982).

Fear, subservience and isolation

Relevance

The research findings suggest that feelings of worthlessness inevitably impact the ability of women experiencing EDs to interact socially in a way which does not encourage their subservience or subjugation. Therefore, authentic intimacy in an equal relationship is often an impossibility. This insecurity often leads to doubting the trustworthiness of God, avoiding intimacy with Him and the subsequent psychological distress of being rejected by Him. There is a desire to be loved yet fear surrounding feelings of worthlessness and low self-esteem appears to be a destructive force in intimate relationships.

Response

As touch and love are undeniably related in the Bible (Luke 3:15-17, 21-22) the lack of touch in contemporary society could be a related reason as to why isolation is most commonly the default reaction for those experiencing EDs. Isherwood and Harris, (2014, p.43) explain "[f]eminist theology has encouraged engagement with raw/radical incarnation and the vulnerability and bravery to feel and to touch: to understand Christian theology as a skin-on-skin activity, a face-to-face mutual engagement of ever fuller becoming." This perspective meets communities which endorse individualism through building walls with a challenge to embrace vulnerability and love in a more deep and meaningful way. Touch expresses unity and communion through holding and letting go and feels attached and detached. When washing his disciples' feet, Jesus said: "If I do not wash your feet, you are not in fellowship with me." (John 13:8). Isherwood (2002, p.53) believes that "Jesus exercises his power through loving and relating (Mk 10.45), and the women do the same, (Mk 1.31; Mk 15.41) but the men are concerned with who should be first (Mk 10.37)." As interpersonal disconnection through isolation combined with a low ability to feel loved is a constant feature for those experiencing EDs, therefore, love and relationships are of utmost importance in recovery.

Therefore, church communities must seek to find new ways to connect and bring these women into the experience of communion. Isherwood (2002) believes that difficulties commenced when interpretations of scripture gave priority to the mind, thus encouraging dualism. To illustrate this, she refers to the woman with the haemorrhage, in Mark's narrative the interpretation suggests that as the woman touches Jesus but, in Matthew's narrative, it is only Jesus' mind that is moved. However, both Isherwood (2002) and Moltmann-Wendel (1986, p.125) argue that although patriarchy has buried the theology of touch, it can be recovered.

As nurturing relationships are crucial for development, security and exploration, this area is closely related to vulnerability, intimacy and openness, and is inseparable from touch. Christ modelled sharing and was not afraid to touch and be touched, Isherwood (2004, pp.146-147) explains "Feminist theologians who engage with bodies celebrate the fact that our stories portray Jesus as a very earthy man sharing touch…" Feminist perspectives challenge contemporary views on the necessity of touch as being inseparable from love and encourage rethinking how we approach this area in church communities. The impact of a practical outworking of a theology of touch and how this could be explored safely in church communities will be further explored in Chapter Six.

Therefore, the dignity deriving from gifting and calling is a functional part of the *imago Dei* and crucially important in application to the self-esteem of those who have experienced EDs and struggled with subservience. As women who have experienced EDs often suffer from low self-worth and chronic feelings of self-hatred which leads to a sense of purposelessness and feelings of incompetency. Therefore, to intrinsically know that one is has been given a gifting and calling is significant in feeling a sense of purpose through the ability to contribute meaningfully hence the uniqueness of their design is recognised which inevitably contributes to self-esteem. Furthermore, when recognising that a sense of agency comes from self-esteem, self-nurturance becomes an imperative and rather than feeling controlled by food as described on p.123, this could contribute to exercising a sense of authority over food in a healthy, non-destructive manner.

The performative approach has also significance in speaking to those experiencing EDs' difficulties with subservience and fear and makes more significant the sense of the purpose and choice of being made in the *imago Dei* wherein there is a sense of gift but also agency. This moves away from fear associated with the damaging aspects of polarised thinking to a sense of agency, which encourages a legitimate way of exercising control in one's life. As described on p.129 the research findings suggest that feelings of worthlessness inevitably impact the ability of women experiencing EDs to interact socially in a way which does not encourage their subservience or subjugation. Subsequently, developing authentic intimacy in an equal relationship is often an impossibility. When considering that socially constructed scripts are often performed as Jones suggests, the power to perform love being self-love and love of others is essential for these women.

5.5.4 Shame — Feminist views on Christology and shame

Abuse and shame

Relevance

Approximately two-thirds of the women who experienced EDs recalled a history of traumatic abuse-based experiences. Therefore, disempowerment has been an integral part of their existence. The most dominant traumatic experience referenced was sexual abuse, and in all of these cases men were the perpetrators. Therefore, it is unsurprising that these experiences have been considered to be contributors to feelings of powerlessness and helplessness and subsequent difficulties in relationships with men.

Response

Many traditional teachings on theological anthropology have perpetuated androcentric theological principles and by consequence this distorted, patriarchal vision of human nature has disempowered and subordinated women and furthermore encouraged a false and unethical sense of empowerment for men. Historically, because women were seen as a source of potential temptation to men, they needed special control in order that they make good decisions. Feminist theologians have expressed distress regarding this atonement model used by fundamentalist communities which commends the divinely mandated

suffering of an innocent victim and emphasise that is as a nefarious encouragement for domestic abuse victims to accept their abuse as if it were God's will. Murphy (2016, in Isherwood and McEwan, p.90) explains “So women suffered from a double burden of guilt and shame first for sharing the fallen human condition, secondly for being born as the weaker half.” Furthermore, De Beauvoir’s (1952, pp.xvi-xviii) statement epitomises the effects of patriarchal interpretations of the fall: “[t]hroughout most of the world, women play the role of the designated other therefore they tend to characterise and carry the projections of all that is threatening and undesirable in human existence, including sexuality, sin, and mortality." As women experiencing EDs already perceive themselves as disgusting; the deep levels of shame experienced contextualise De Beauvoir's argument as firmly placed within the Church. This sense of shame correlates with the findings as half of those who sought help from churches expressed disappointment about the quality of care they received as feelings of increased shame contribute to a stigma which increases the experience of emotional isolation.

Creating an empathetic connection and thus relationality is of vital importance in the recovery of those who have experienced EDs which therefore means that both feminist theologians and those adopt a more reformed position such as Jones (2009) and Moltmann-Wendall (1991) can reach common ground whereby the importance is focused on the empowerment of the individual without diminishing the power of the crucifixion narrative. Therefore, although feminist theologies move away from traditional interpretations of sin and focus on the innate goodness of humanity, emphasising the importance of owning one’s erotic power, the unjust and brutal nature of the crucifixion does not have to be disregarded. Rather, the true redemption narrative neither justifies victimisation nor disempowerment rather the emphasis is on the life of the relational Christ who suffered and died unjustly yet defeated death in His human body bringing a life-giving theology of the cross. As the redemptive hope of the future “is itself the happiness of the present” (Moltmann, 1967, p.32), those experiencing EDs and their carers could find a place of rest, free from internal and external oppression, in the church community, or rather this is best described as in the body of Christ. The identification of women with EDs can thus be ‘completed’ by an identification with the risen Christ and this is what brings hope. If Christ is the emaciated, rejected, ugly one is actually the powerful one, what has been deemed vulnerable is translated into powerful

because of what he actually is in himself, that being divine. Therefore, women who are, or perceive themselves as ostracised from themselves, God and community, can be affirmed and 'resurrected' because of who they are: bearers of the image of God. Innocent victims can then become resurrected bearers of a new quality of life.

A feminist interpretation of scripture is not only essential for women but also for men to help reframe views on the objectification of women and further encourage authentic mutual respect. The emotional distress intensified by shame over past perceived failures is common to all of those interviewed who experienced EDs, particularly those who have experienced abuse, making these women particularly vulnerable to further subjugation. It is without question that the violation of vulnerability is most accurately displayed when the trust of children is abused in tragic cases of sexual abuse, violence or neglect. As the aim of Christian practice is to help overcome alienation and exclusion, particular emphasis must be on the enablement of those who have experienced shame, often through no fault of their own, to see themselves, others and God as they truly are. These feminist perspectives on the crippling effects of shame as a hindrance to authentic vulnerability are most evident in rehabilitating texts such as Genesis 2:25 where Adam and Eve were naked but not ashamed. The body is used in the creation narrative, before the fall, to symbolise transparency, the communion of persons, trust and uninhibited love where intimacy with each other and God flourish; shame, however, involves issues of distrust and fear and therefore debilitates the capacity for vulnerability.

As shame causes silence and stigma, emotional isolation and lack of intimacy with God, these difficulties must be sensitively addressed for women experiencing EDs. An embodied practice, which encourages intimacy over judgementalism opens up possibilities for the entire church community to be used in compassionate interpersonal relationships to help reduce crippling feelings of shame.

5.5.5 Compassion — Feminist views on Christology and relationship

Trust and relationship

Relevance

The majority of those who mentioned abuse also emphasised their subsequent low ability to trust themselves or others, leading to increased levels of fear; this is particularly relevant in relationships with males. Therefore, for many of those who have experienced EDs, it was difficult to trust in the longevity of friendships and intimate relationships. Conversely, understanding partners and close friends appear to be the most therapeutic relationships which aid in recovery.

Response

Although there have always been alternative traditions of women's leadership and theology, patriarchal models have always dominated. When questioning the androcentric logic of Christology, Daly states, "if God is male, then male is God" and implies that if this is the case, then it would seem illogical for men to want to give up such an identity. Therefore, Reuther (1988) and Daly both suggest that the very limitations of Christ as a male person must lead women to the conclusion that he cannot represent redemptive personhood for them. The submission of women is part of the behavioural requirements in relationship dynamics with men in fundamentalist communities. Therefore, gender inequality is closely related to identity. From a feminist perspective, wholesome relationship dynamics are by necessity equal. Heyward (in Isherwood and McEwan, 2016, p.52) explains “[e]mpowerment is a process in which one's sense of personal identity is enlarged to include the quality of one's relationships with others in the world. In this way, being a ‘person' means not simply being ‘oneself' but being in relationship-to-others." Purposeful relationships can provide support especially during periods of deep distress and in these periods a deeper understanding of oneself, others and God can occur.

Johnston (2002, p.161) explains, “The problem is not that Jesus was a man but that more men are not like Jesus.” Feminist theologians radically challenge the church to reconsider the patriarchal images of God and Jesus which have been enforced by a dualistic Christian heritage and suggest that the relationship between males and females can be reframed and

church communities have the potential to empower rather than disempower women. Women's traditions have often been marginalised especially through the canonisation processes in which feminists argue that women have been recorded as attendants, but not participants; this being a factor which relegates women to an immediate second. However, through a feminist reading of scripture, recognising women as the main witnesses and proclaimers of the crucifixion and resurrection suggests that women are to be trusted and have a definitively equal role to men in the gospel narratives as evangelists and credible witnesses. As so often the Christian heritage has been oppressive for women and made living in female bodies particularly difficult, and for the past centuries women have lived under a patriarchal Christology. However, when Jesus' relationships with women are explored in their historical context with a focus on the embodied love of Christ, the Christian story develops meaning in a more gynocentric way. Jesus is reported to offer women not only a safe presence but also empowerment through leadership despite the norms of his culture.

Healthy relationships are crucial to recovery for those experiencing EDs as positive treatment results correlate with security in interpersonal relationships. Therefore, a theological understanding of interrelation in the Trinity is essential. Central concepts of feminist Christology are connection and relatedness. However, relatively few feminist theologians have provided sustained, full-length studies of the Trinity in such matters (Bacon, 2009, Coakley, 2008). Bacon (2009, p.7) states that she strives to "assess the doctrine of the Trinity by its ability to affirm the key principles and values underpinning a feminist theological method which takes women's experience as its starting point". However, for many feminists, there is a discontent with the androcentric nature of descriptive language found in traditional discussions of the Trinity, as God is depicted as a coercive, and controlling monarch who both justifies and supports abusive relationships. In light of this, Ruether (1983) advocates a return to encounter with the message and praxis of the Jesus of the Synoptics, in recognition that his critique of oppression and sensitivity to emotions parallels that of the feminist critique. Isherwood (2002, p.55) explains, "Our Christology needs to begin in our deepest form of connectedness and in our ability to create and sustain relationships, we have to allow ourselves to feel." By theologically examining 'what is right' (Bacon, 2009) with the Trinity, feminists can gain valuable guidance about the eternal activity of the being of God and God's

actions with humanity, which can lead to fruitful contemplation concerning self-compassion, difference and subjectivity. For all those who experienced EDs, trust is essential to feeling safe enough to share their story. The sense of finding a safe space to trust and find authentic relationships and community is thus fundamental in empowering those who have experienced EDs.

5.5.6 Control and Power: Feminist ecclesiology and negative church-based experiences

Power, patriarchy and Church communities

Relevance

Approximately a third of those claiming insight assert that a sense of oppression around sexism in churches is related to a broader issue in society as a whole. Religious authority being misused to manipulate was a concern for approximately a third of those claiming insight, particularly in the realm of mental health. Moreover, religious institutions were often referred to by women who experienced EDs as oppressive, patriarchal and judgmental and a few suggested that some church leaders and members try to control and manipulate those who are vulnerable.

Response

Feminist theologians agree that patriarchy and male dominance is still an issue in many church communities, and women must seek to challenge this (Glaz and Moessner, 1991; Isherwood, 2008). The goal, in one sense, is to reconfigure the present and future and, in another, the past needs to be transfigured from a history of oppression into a history of wisely remembering the suffering of those who have been marginalised, particularly, in this case, the lives of women. An essential aspect of the feminist redefinition of ecclesiological discourse lies in identifying, deconstructing and essentially reclaiming those aspects of ecclesiology which have become theological means of excluding women from discourses of ecclesial praxis. These can be seen as the locations of patriarchal power which, historically, has dominated ecclesiological discourse. Therefore, due to these perceptions of power, there is little belief from a feminist perspective that residing in a religious institution could be conducive to recovery. Ruether (1983, pp.18-19) expresses this principle as follows: “The critical principle of feminist theology is the promotion of the full humanity of women…

Theologically speaking, whatever diminishes or denies the full humanity of women must be presumed not to reflect the divine or an authentic relation to the divine, or to reflect the authentic nature of things, or to be the message or work of an authentic redeemer or a community of redemption."

As feminists such as Reuther (2001) suggest that an understanding of ministry and clerical ecclesial structures are diametrically opposed to each other, does this bring us back to issues of the correct use of power and love? Brock (2008, p.49) emphasises that we should no longer see Jesus as a hero and accuses Christianity of having a wrong view of power, "Christianity is afflicted with a hierarchical view of power that undercuts its understanding of love in its fullest incarnation that we are all part of one another and co-create each other at the depths of our being." Brock emphasises that it is this issue of power which is integral to the problems with traditional atonement theology. Brock is suggesting that by giving back power to Jesus and refusing to see him as the victim, we also see the Christ as an image of shared power that increases in the sharing rather than as a once and for all event in the person of Jesus. So, instead of the hero and victim categorisation, Brock (2008) Heyward (1982) and Isherwood (2004) suggest that Jesus' and our vulnerability is the correct manner of focusing on just and healing relations. Coakley (2008) believes that the imagery of the Trinity contributes to an understanding of the dynamic nature of relationship for both males and females, despite the traditional language speaking of "Father, Son, and Holy Spirit" which appears to give priority to male imagery. Linked to this there is a form of feminist theology which seeks to identify and rectify power imbalances arising from gender issues. Coakley (2008), from this perspective, invites the reader to re-conceive this imagery as based on the Trinity as desire for and from God rather than a sense of oppression or coercion.

Unhealthy power dynamics in some Church communities have paralysed many women's capacities to have personal relationships with God. Furthermore, these institutions often appear as the gatekeepers to God, so that many women have cut themselves off from the potential of ever having a relationship with God. It may be that this has caused irreparable damage in the lives of some women and for them, church communities will never be a safe space. However, for others, when considering the potential for transformation drawing from

the thought of feminist theologians, church communities do have the potential to develop a safe environment for women that is characterized by stability, equality and respect.

5.5.7 Views on the church/statutory care as supportive to recovery — Feminist ecclesiology and community, including negative church-based experiences

Words, 'The Word' and Community

Relevance

Approximately half of those claiming insight suggest a need for sensitivity when using religious language in church communities, as inappropriate use could further compound feelings of false guilt. Alternatively, about a quarter of those claiming insight deem religious terms such as 'sin' and 'repentance' as essential.

Response

Chopp (1989) employs part of the canon of symbols of traditional Christianity, even though she re-defines them. The terminology of 'sin' and 'grace' are central to her ecclesiology. The church, or, as Chopp, (1993, p.52) following Fiorenza, prefers to call it, the *ekklesia*, is a place "which opposes patriarchy and which envisions new ways of flourishing, or what I speak of in terms of the denunciation of sin and the annunciation of grace." The centre of Chopp's (1989) ecclesiology is the spoken, preached Word. She views 'the Word' as the perfectly open sign which essentially can be understood as empowerment to speak. It is central to Chopp's (1989, p.94) ecclesiology that women experience themselves as participating in this process of speaking and interpreting 'the Word,' the main task being the proclamation of "emancipatory transformation". According to Chopp (2002), the community precedes the individual, the individual cannot be perceived as outside of particular social structures, be they oppressive or liberating, and both community and individual are subject to constant change and transformation. For Chopp (2002) 'the Word' can transform the social-symbolic order when it is proclaimed with the goal of changing its institutions, principles and structures. Therefore, feminist views on empowerment, suggests that because Christian language was created within the framework of patriarchy, it is the major contributor to the social symbolic order; however, this has the potential to change.

'The Word' when emphasizing the importance of embodiment and indeed Christian language creates and constitutes the life of the embodied community. When considering the bibliocentricity of fundamentalist-like communities, the rigidity experienced in this environment is deemed by feminist theologians to disempower and to use 'The Word' in a way which causes unhealthy power dynamics. Therefore, there is a need for the church to exercise particular care and sensitivity mainly when dealing with the issue of guilt in those who have experienced EDs as words are extremely important in the formation of self-image for these women.

Oppression and Church

Relevance

There is a belief amongst approximately two-thirds of interviewees who claimed insight that church community could provide a helpful and supportive environment for those recovering from EDs. Further, approximately a quarter of the women who experienced EDs suggest that being reassured of their purpose in God as part of their identity has been an integral part of their recovery journey.

Response

If women in church are traditionally positioned as submissive within heteropatriarchal relationships that are its most fundamental structure, do women's sufferings in religious patriarchy have to be explored structurally in order to set free the emancipatory power of the Christian community? Chopp (1989, p.84) explains, "Feminism's theological reconstruction of Christian community can begin with Barth by asking how, within the words of women, community is created in, with, and through the Word in the reception of the Scriptures and the reality of emancipatory transformation." Chopp, (1989) suggests that patriarchy is a web of sinful, destructive relationships of oppression. However, feminist theologians recognise the ekklesia as the space where these structures of patriarchal oppression and sin can be analysed as well as denounced. When church community has unhealthy power dynamics, hierarchy

becomes damaging, and oppression and marginalisation of the vulnerable are evident. As Keller (1986) reflects on the disempowerment of women as part of Western society's patriarchal heritage, she affirms that in contemporary culture the empowerment of women is of the utmost importance.

However, it is recognisable that unhealthy power dynamics in some Church communities have paralysed many women's capacities to have personal relationships with God. Furthermore, because these institutions often appear as the gatekeepers to God, many women have cut themselves off from the potential of ever having a relationship with God. It may be that this has caused irreparable damage in the lives of some women and for them church communities will never be a safe space. Daly (1993) denies to the church all empowering potential for women. Similarly, the majority of those who experienced EDs suggested that church communities would have little to contribute to effective care for those struggling with a mental health issue. Therefore, it is evident that there is an apparent distortion of the concept and image of what church communities are and of who God is (Dykstra, 2005). These perceptions may be accurate, given that the majority of those claiming insight were adamant that church communities need help to change before they could hope to provide a suitable environment for those recovering from mental health issues. Fiorenza (1991) reframes the concept of the church by returning to the original interpretation of *ekklesia*, and its effect on community and discipleship in the early church. Fiorenza (1991, p.15) explains, "To link *ekklesia* or church with women makes explicit that women are church and have always been church. It asserts that women have shaped biblical religion and have the authority to do so. It insists on the understanding and vision of church as the discipleship of equals." The term 'women-church' or *'ekklesia* of women' is a paradox that indicates that *ekklesia* will become a historical reality only when women are fully incorporated into it. Women-church is therefore not an exclusive term concerning men but rather seeks to make conscious the reality of women's exclusion from ecclesial processes of decision making. When one takes ownership of their life, makes decisions for oneself and refuses to be subservient to men, this correlates with the concept of women-church and thus suggests that this could be a particularly empowering structure for women experiencing EDs. Using a term like women-church means that the traditional, patriarchal church can no longer claim to be the sole

representation of church, let alone a realisation of the dynamic reality of the *ekklesia* (Ruether, 1985). When church communities embrace radical regimes of equality and empowerment for women, this will embody authentic love which becomes the foundation of hope. Women-church could socially construct a fertile environment for safe recovery particularly for women who have felt ostracised in the church. Women then will have the potential of moving from hurt to healing, which could emerge as a tangible manifestation of the resurrection hope; visible through loving relationships in the collective church community.

Conclusion

The praxis of Jesus is one of fundamental openness to those marginalised and excluded that is to be continued by the church in its praxis of hospitality, as the love of God is mediated and cascaded through the witness and care of a community grounded in love. Although being part of a fundamentalist-like community is most likely to cause further subjugation for those experiencing EDs, however, it is apparent that identity cannot be found in isolation, therefore, through letting go of the need for individualistic certainty in temporal existence and looking toward a relational embodiment and indeed resurrection, hope becomes possible. As emphasised by feminist theologians, it is the central task and raison d'être of the church to maintain a critical presence in the world, symbolising the possibilities of community through right relationships and the potential for flourishing. Therefore, women being fully integrated into safe communities is imperative. The potential practical implications will be developed in Chapter Six.

Chapter Six: Revised practice – the practical outworking of the conversation.

6.1 Introduction

The contributions which have aided in forming a practical theological response have emerged from the research findings, synthesised with an understanding of the condition of having an ED, the context of a fundamentalist like environment and challenged by insights from feminist theology. The embodiment of Christianity through spiritual practice is the necessary endpoint for this thesis given that theology without practice could be deemed to be hypocritical! This thesis has highlighted the difficulties associated with disembodiment, therefore it must authentically promote practices which are themselves an expression of embodiment. As this thesis is epistemologically grounded on post-structuralist social constructionist thought, there is an underpinning belief that expressions of human experience are inevitably influenced by cultural practices, institutional structures and the dynamics of power (McClure, 2011). This social phenomenon accepts that one's self-understanding is significantly impacted by and entangled in social roles, power and status. As Feminist theologians (Isherwood, 2004; Heyward, 1982; Brock, 2008) emphasise, disembodiment originates from the damaging effects of dualism which is deeply embedded in the patriarchial Christian tradition. They suggest that this kind of practice has distanced people from themselves, others and God and furthermore marginalised and oppressed the vulnerable and they declare that this must be rectified through new theologies of embodiment. When one's social influences change, there are opportunities for positive change; the questions I have considered are: Do the social influences of church communities help or hinder women's' recovery from an ED? If they are potentially damaging, can these influences change to help women recover through the support of church communities? Although each church community is unique and there is not a 'one-size-fits-all' solution for those experiencing EDs, the church could invest more into creating a curative environment and be better equipped with renewed methods for pastoral care. The recommendations of this thesis thus develop and conclude on the significance of the four main findings and consequently offer proposals that will help form a new model of pastoral care, which aims to aid as a preventative measure to help safeguard women who may be vulnerable to developing EDs and also aid in the restoration of women who have

experienced EDs. The chapter will conclude with some questions for consideration beyond the scope of this thesis.

Deriving from Feminist theologians' challenges to oppressive male-dominated ecclesiological structures which negatively influence human flourishing and practical care, these concluding sections offer some direction by suggesting new patterns of pastoral care and patterns of church life in general to better care for women experiencing EDs. Feminist theologians challenge patriarchal approaches to care, and alert us to contextual objectives that value women's insight, experiences and perspectives on care as both care receivers and caregivers.

This concluding chapter will be divided into three sections:

Section 6.2 will critically analyse the four key findings which have emerged as vitally important themes in caring for women experiencing EDs. These findings will be analysed with an awareness of the social construction and impact of fundamentalist-like communities and will use the challenge of feminist theology to offer suggestions to transform the present praxis of pastoral care. When considering the potential for transformation drawn from the thought of feminist theologians, church communities do have the potential to develop a safe environment for women which emanate safety that derives from awakening to the immanence of God and also the transcendence of God through the presence and stability of the community. However, it is evident that these four key findings require due consideration and practical response if this is to become a reality.

First, we will consider **vulnerability.** The majority of the women who were interviewed feel perpetually unsafe and persecuted by their thoughts. Therefore, their sensitivity to threat is often heightened, causing an emotional vulnerability. Furthermore, for those who experienced repeated traumatic events, this had a significant impact on their capacity to trust themselves and others that added to the sense of vulnerability. Consequently, a lack of safety, insecurity, and avoidant, fear-based behaviour were common to the majority of the women who experienced EDs.

Second, we will consider **power**. A disturbingly painful relationship with power is evidenced through the interviews with the women who experienced EDs, as the majority felt resentful towards their propensity to be submissive and their desire to please others. Many of these women admitted to feeling disempowered, oppressed and trapped on a repeated basis. Moreover, religious institutions were often referred to as oppressive, patriarchal and judgmental. As these institutions appeared as the gatekeepers to God, this often paralysed the women's capacity to have a personal relationship with God and instead invoked fear. Therefore, due to these perceptions of power, there is little belief that residing in a religious institution could be conducive to recovery.

Third, we will consider **embodiment.** The experience of mind-body splitting is common to all interviewed who experience EDs. Furthermore, the varying degrees of disembodiment, caused by splitting is epitomised by the self-objectification of almost all of the women interviewed who experienced EDs. Feelings of self-hatred and attacks upon one's body exemplify the dissonance between body and mind. For many women experiencing EDs, the 'perfect' body is desired and seen as a means by which she gains respect; consequently, this externalisation results in objectification. Thus, their body does not feel like their own because it seems to be ruled by others around them as they adopt a habit of self-objectification in their efforts to attain culturally enforced ideals of beauty.

Fourth, we will consider **creativity.** Creativity is a significant part of recovery for approximately three-quarters of the women who experienced EDs. Two important aspects of creativity are as a distraction from the ED and an expression of emotion. When imaginative capacity was inhibited, this had an effect on self-worth and was especially prevalent during the worst stages of their disorder. Furthermore, creativity was symbiotically correlated with recovery.

Section 6.3 will draw some conclusions on the praxis of pastoral care and give direction on reforming present practice. Through critical analysis, five areas have emerged of particular importance: Listening, wisdom, safety, identity and hope, the significance of these areas is outlined below. The section will also include suggestions for renewed practice, which will engage with three groups: experts-by-experience, pastoral carers and the church community.

Listening is of particular importance considering that many of these women who have experienced EDs have felt perpetually unheard and unable to express their emotions,

Wisdom is of vital importance considering that the reports of the manner in which pastoral care has been approach has been particularly unwise and also given the noted hypervigilance of those experiencing EDs.

A safe environment is essential considering that all of the women interviewed reported feeling chronically unsafe in their bodies in many instances due to traumatic experiences, they are often distrustful of both themselves and also those offering care.

Issues of identity and negative cognitive patterns must be addressed as the desire to please others causes a destabilisation in the development of a consistent identity and thus hinders rehabilitation.

Inspiring hope and a sense of meaning, irrespective of the darkness of the situation are essential to rehabilitation in a context in which depression was notably a comorbid condition of all those interviewed who experiencing EDs.

The chapter finishes with **two concluding proposals** and some final comments

The first proposal concerns potential collaboration with the NHS. When considering the current financial restraints on the NHS as evidenced by the waiting times for those experiencing EDs, there is a definite need for further support. The support is evidently needed in the interim period post initial contact with GPs, given the evidence supporting a decline in condition if interventions are delayed, and post-treatment as there is evidence of relapse if appropriate support structures are not in place (see Appendix 5). The second proposal is a set of questions for further reflection beyond the scope of this thesis. The final comments bring the thesis to its natural conclusion

6.2 Conclusion on the significance of the four key findings

6.2.1 Vulnerability

Although vulnerability is sometimes linked to victimhood, (Walklate, 2012) admission of vulnerability is more of a realisation of part of the human condition than an option. Therefore, there is liberation in admitting vulnerability as this removes the stigma of perceived failure because weakness is an inevitable part of what it is to be human. Brock (2008, p.17) says, "Heart is our original grace. In exploring the depths of heart, we find, incarnate in ourselves, the divine reality of connection, of love… But its strength lies in fragility." Stemming from Heyward's (1982) thoughts on *dunamis* and erotic connection, this raw energy is truly embraced in open vulnerability and mutuality in relation with others. Isherwood (2004, p.147) explains "we need to reconnect with our unfolding history of intimacy and empowerment." Intimacy is not possible without vulnerability. If vulnerability is closely linked to honesty, then confession and forgiveness are intertwined with vulnerability; therefore, a sense of vulnerability in prayer fosters intimacy with God. As personhood is inevitably linked to relationship, being a 'person', means not simply being 'oneself' but being in relationship-to-others, therefore how one views oneself has a distinctive impact on how one is in relationship to others. The divine incarnation and salvific power in human life must reside in connectedness and not in single individuals. The interactive process of erotic power makes essential the give and take quality of intimacy among selves. Decisions and actions are not caused by one person but result from historical circumstances and from our deep relatedness to other persons. As those experiencing EDs accept and fully become aware of the interconnectedness of humanity through erotic power, this will address issues of isolation and loneliness as they gradually surrender individualistic tendencies. By building a secure base, church communities can provide an optimum environment to cultivate erotic power, protection and safe boundaries. In this stable base, the individual who is in recovery should be free to test limits without fear of retribution, as the church community exercises unconditional love and acceptance. Therefore, a community environment that promotes

erotic power through interconnectedness has the potential to provide the optimum healing environment to cultivate a more secure sense of self.

Brock (1992) characterises the self's tendency to dissociate from emotions of vulnerability, anger and grief when parents have not affirmed the appropriateness of these emotions. The dominance of this approach of 'power-over' the child causes a numbness, an inability to process painful emotions in the splitting of owning and disowning emotions, subsequently fragmentation occurs. Brock (1992, p.xv) compares this experience to patriarchal socialisation in the family especially through fixed gender roles and refers to the "ravaged, faint, fearful broken heart" of those who have suffered under patriarchy damaged and weakened from its state of original grace. Emphasising the importance of awakening these emotions through the senses, Rambo (2010, p.162) explains, "[r]estoring the sense of trust and meaning is not purely cognitive; it involves a different sense of the world instead. Sensing life is this kind of reconnecting process; it is an exercise of imagination in the face of what is unimaginable." When reconnecting to the world, assuring safety is the primary task in care. In accord with Herman's (1992) emphasis on safety and Calvin's theological framework, Jones (2009, p.56) explains that in Christian contexts the sovereignty of God can provide "a profound sense of safety." She (2009, p.56) further explains:

> For persons whose world has been knocked out of kilter by traumatic events, the invocation of divine control can serve to stabilise their seemingly unstable reality by bringing order into the midst of profound disorder. With this stabilisation comes the possibility of imagining that one is, in the most ultimate sense, safe.

Relinquishing one's control and trusting God would appear to be the ultimate sacrifice of self-agency and could be experienced as counterintuitive to recovery. However, trauma literature suggests otherwise; that this acts inversely (positively) and affects one's sense of personal agency (Jones, 2009). Reflecting on Calvin's (1845) instructions on the art of prayer, Jones (2009, p.56) explains that, as an initial step, he invokes "… the reality of God's sovereignty because this dimension of divine identity provides the traumatized with a profound sense of safety, which they so strongly lack as they wander in the world of the dead." This hollow, emotionless existence is common to almost all of those who experienced trauma and was

described as numbness even in the face of circumstances which would certifiably rouse emotions. Building an image of a deity who has shown himself to experience the full range of human emotions is crucial to Christian pastoral care when considering that, for those who have experienced trauma, it is impossible to trust a fear-inducing, emotionally detached God. Instead, safety is found when unconditional love, stability and empathy are sensed as these characteristics are an integral part of God's nature, and that nature should be reflected and embodied in the Christian community. Further contributions to vulnerability can be found in Appendix 18.

6.2.2 Power

Graham's (1996) post-structuralist emphasis on social transformation represents the postmodern insight as Cahalan and Mikoski (2014, p.68) suggests that "[k]nowledge is rooted in particular standpoints and works best by first understanding and analysing the discourses and regimes of power in their own context." Pattison (2000) explains that a presentation of an all-powerful God may not be the most fitting image to present to one who is feeling deep shame. Therefore, although it remains true that, for many, a human response to God's omnipotence, omnipresence and omniscience (Psalm 139) is comforting, for those experiencing intense guilt and fear, these divine characteristics can be experienced as oppressive. McLemore (2012b, p.239) explains, "[t]he emotions affect the quality of our interactions. Being able to discern emotions helps us recognise contradictions and confusion and gain clarity about power relations." By becoming aware that the God of one's understanding is shaped by individual past experiences of authority figures, it becomes possible to reframe the God-image one has in one's mind (Dykstra, 2005). Furthermore, through recognising that God frees those who are imprisoned and is not an unfair judge (Luke 4:18; Luke 18:1-8), refuge and comfort can then be found in the God-image held in one's mind. As women who have experienced EDs reframe and recognise that God does not endorse oppressive patriarchal models of the church community and these are not God's design for women, there is potential to regain their trust in God and the church.

Object relation theory helps us to understand the psychological mechanisms which decide how God is framed by an individual's preconceptions and experiences. As van der Kolk (2011) explains, the perpetrator who oppressed and abused is often internalised and becomes an inner tormentor. Further contributions to this area can be found in Appendix 19. As Kalsched (2014, p.5) explains, "[t]he traumatized psyche becomes self-traumatizing," therefore, the healing process has to be navigated from within. Through understanding this internal oppression, the anguish of those experiencing EDs can be grasped, bringing a deeper understanding as to why the prospect of intimacy with an all-powerful God could be daunting. Leuba (1912) suggests that there is an alternative response to God's omnipotence, omnipresence and omniscience and suggests that it is possible to move beyond fear to awe. He (1912, p.540) writes, "[n]ow in passing from fear through awe to admiration and reverence man advances from the state of a beggar asking for protection to that of a bestower of praises." The most obvious implication of awe filled-worship is a shift in focus away from the self and towards God, with a consequent motivation to help others. However, there are also notable psychological and physiological benefits which could aid in the liberation of those experiencing EDs (Stellar et al., 2015b). As one's fear reduces and there is an appreciation of the powerful, though not oppressive nature of the divine creator, awe is inspired alongside a realisation of one's own power as made in the image of God. Furthermore, Jones (2009, p.46) explains that, according to Calvin, "[s]cripture is never just a book we quietly read; it is a dramatic world we are invited to stand within and to inhabit as our own, a world where we encounter the God of Israel and Jesus Christ who creates and redeems the world." Therefore, as one reframes the vastness of the power of God influenced by a sense of awe and wonder, they become aware that they are an integral part of the theatre of the glory of God. Faber (2004, p.323) explains "The integrity of relation, of 'power-in-right-relation', recovers the infinite within human finitude, the interplay between transcendence and immanence, in movements of opening and closing, of drawing into oneself, and of empathic crossing over to another person." Therefore, when one senses both the transcendence of God and the immanence of Christ, this is an invitation to experience intimacy and to be filled with an immense sense of being loved.

The relational factor in the experience of awe is how we bring one another into being, Harrison (1981, p.47) explains “We do not yet have a moral theology which teaches us the awe-ful, awe-some truth that we have the power through *acts of love* or lovelessness literally *to create one another*.” Heyward (1989, p75) asks rhetorically, “might the struggle for the possibility of relational mutuality be a primordial source for our authority?” Heyward (1989, p75) defines ’authority’ as *dunamis*, "dynamic relational power". Authority is that which is dynamic and life-giving; in the Bible, it is that which leads to fullness of life. In explaining the natural impulse of the body to resist domination and desire connection and referring to those who have suffered abuse and addiction, Brock and Thistlethwaite (1996, p.277) suggests that the “body's truth and compassion” has a natural urge toward healing. However, it stands true that whether internal or external to church communities, the critical first steps toward recovery are centred on developing awareness and recognising how one relates to authoritative figures, whether that be cowering in submission, running in avoidance or trying to destroy the dominant figure. Furthermore, through embracing one's sense of erotic power and through a realisation of one's *dunamis,* the issues of power have the potential to become less focused on denouncing oppressive structures and more orientated towards claiming one's rightful sense of power in equal relationship to others. This has profound consequences for patterns of leadership in church communities.

6.2.3 Embodiment

Emphasising the importance of embodiment through an emphasis on the dignity of being human can transform the individual and the world around that individual, “by the sheer outpouring of our dunamis” (Isherwood, 2002, p.54). Therefore, it is essential to note that embodiment is not individualistic but rather effects one’s ability to form and sustain healthy attachments. Lyall (2001, p.92) argues that “full emotive expression” is an absolute necessity when caring with theological integrity, because God Himself, in whose image humanity is created, uses the full spectrum of emotive expression. Therefore, it is crucial that the full spectrum of emotional experience as documented in the biblical narrative be respected and drawn upon. However, as Jones explains (2009, p.ix), a troubling reality for those who have experienced trauma is that "it is hard to know God when your knowing faculties have been

disabled … it is hard to feel divine love when your capacity to feel anything at all has been shut down." Therefore, reducing the fear of reawakening the emotions is imperative in recovery.

The necessity of understanding one's emotional functioning is not well understood in church communities. As Pattison (2007, p.185) admits, "Christian thought has reflected and reinforced emotional illiteracy." As the essence of what it is to be human means feeling emotions including pain, it is essential that these are not interpreted abstractly, but rather are felt and experienced. Whitehead (2010) emphasises that the embodied nature of emotions in theological anthropology is crucial as this inevitably influences one's relationships and imaginative capacity. For safe trauma recovery and the healthy integration of emotional experience, Rambo (2010, p.162) explains, "[r]econnecting people to their own breath is an essential first step in trauma healing." Rambo (2010, p.162) imagines the "Spirit as Divine Breath," therefore through contemplation in meditation, an attentive focus on the Spirit as the life-giving breath could be an aid to connecting with one's body.

Understanding attachment styles help to guide insight into potential obstacles on the pathway to cultivating a deeper relationship with, and attachment to God (Akrawi et al., 2015). Some theorists suggest that God may function as an archetypal substitute attachment figure for many who lack the security of crucial interpersonal relations (Strenger, Schnitker and Felke, 2016). Feelings of inadequacy and shame in those with an insecure attachment style would particularly impact upon perceptions of God's security, availability and dependability. Fear and doubting the trustworthiness of God may lead to entirely avoiding intimacy with God in an effort to avoid the psychological distress associated with rejection by God. Therefore, understanding attachment theory is important in pastoral care as it may help explain why difficulties with one's concept and image of God exist. Further contributions to this area can be found in Appendix 20.

As the attachment dynamic experienced relationally with one's parents most often impacts on one's view of God, it is relevant that women experiencing EDs are often perfectionistic in

their idealisation of the father figures in their lives (Cook, 2016). Due to the inability to live up to their own perfectionistic standards, those experiencing EDs often feel profound inadequacy and shame which can significantly impact upon their perceptions of God's love for them, His availability and His dependability. Dykstra (2005) views God concepts as a way in which one can cognitively strengthen their understanding of God's character as an archetypal attachment figure, even when faced with negative God-image experiences. Negative God images of God as a patriarchal figure, at worst abandoning his son to a cruel death on the cross, can cause insecurity and anxiety in one's relationship to God. However, when this is reframed as the suffering God on the cross this causes a shift in perception revealing more of God's rich personhood. This emphasises the need for an understanding of the Trinity and in particular the community and oneness of God, Christ and the Holy Spirit. Louw (2000, p.69-70) therefore suggests that God's omnipotence should be perceived as a dimension of "suffering and our social reality" and "interpreted and perceived in terms of grace, mercy, servanthood, and sacrifice", it also reveals God on the borderline between 'faithfulness and vulnerability' (Louw 2000, p.70). As the God-image is emotion-based and develops through feelings evoked in the experiential attachment to God, and the God concept emerges through one's practices concerning God, Dykstra (2005) suggests that renewing God-concepts helps regulate these negative experiences.

Dykstra (1986) explains that God-images and God-concepts are not synonymous. The God image is often one's experiential comprehension of who God is on an affective level (Moriarty and Hoffman, 2014). Moriarty and Hoffman suggest that the God concept is one's cognitive comprehension of God, which is signified as one linguistically communicates one's knowledge of God. According to Dykstra (1986, p.170), the God concept is "not just to enable mutual interactions to take place in constant reference to the believer's way of life," rather, "[i]t functions to provide the [faith] community as a whole with a means both to maintain itself over time and to test its actual life over against what is most essential to it." Dykstra (1986) views God concepts as a way in which one can cognitively strengthen one's apprehension of God's character as an archetypal attachment figure, even when faced with negative God image experiences. Negative God image experiences often cause insecurity and anxiety in one's relationship to God. Dykstra (1986) suggests that God concepts help regulate these

negative experiences. Positive God concepts as modelled by church communities, (whether this be in a pastorally sensitive traditional church community or women-church) could help to balance the disorientating effects of a God image crisis (Dykstra, 1986). The disfigured image is corrected by the concepts of safety, strength and wisdom which are integral to the character of God. A God concept can manifest an internal calmness, or, when negative, it can cause the opposite effect of insecurity and division (Davis, Moriarty and Mauch, 2013). God concepts act as a form of language and communicate a sense of hope, security and identification. Although concept and image are different, Moriarty and Hoffman (2014) believe that they form symbiotically. The God image is more emotion based and develops through feelings evoked in the experiential attachment to God, whereas the God concept emerges through what one has been taught and through one's linguistic practices concerning God. As a sense of embodiment and wholesome attachments are essential for flourishing, creativity and spiritual restoration, Hunsinger (1995, p.58) suggests that the pastoral carer "seeks to become not only a trustworthy 'good object' to the counselee but also a reflection, however fragmentary of the goodness and trustworthiness of God."

If negative God images can be regulated through God concepts and cause more secure patterns of attachment, one of the most important factors relevant to the discussion is the concept of non-duality. Eisland (1994) and Isherwood (2008) radically challenge the church to reconsider the patriarchal images of God and Jesus which have been enforced by a dualistic Christian heritage. Keating (1994), Rohr (2003) and Bourgeault (2004, 2016) have written extensively on this as part of the contemplative tradition in Christianity. They support the view that Christian practices can aid individuals in cultivating intimacy with God and provide an experiential understanding of non-duality which is supported by the Bible (Ps. 139:8; Luke 11:34; Gal. 3:28; Matt. 5:43-48). Furthermore, Isherwood and Harris, (2014, p.43) emphasise that this chasm can be bridged through engaging with one another in a community through a sense of one's erotic power. They emphasise that "[d]ualistic theology rips us from ourselves and cauterizes us, enfeebling our judgement, our heart, our passion". The concept of non-duality emphasises the reality of wholeness, and that separation does not exist; instead it is a mirage of consciousness created through distressing emotions.

Isherwood (2008, p.4) explains how so often our Christian heritage has been oppressive for women and made living in female bodies particularly difficult, "It is difficult for women to be fully embodied under patriarchy." It is evident that the Christ of dualistic thinking distorts one's relationship to the body and creates a sense of alienation in the pseudo-struggle for spiritual perfection. Isherwood (2004, p.143) explains, "We will have to look again with courage and imagination at metaphysics, at the dictation of Word becoming flesh and hijacking wisdom, at risk, and what that really requires, and at power. We will have to engage with new questions, questions that we never thought possible." Although denouncing that which is oppressive is important in the empowerment of women, claiming power through embodiment is essential, and it comes through the awakening of one's senses. Moltmann-Wendel (1986, p.125) explains "The word, which became so overpowering above all in the Protestant churches, is only an accompaniment to this experience of the senses". Furthermore, in the accounts of Christ's interactions with women, Isherwood (2002, p.55) explains "[The experience of the senses] is particularly noticeable in encounters with women, while those with men tend to remain wordy and thus their dynamic is restricted." The issue of embodiment through the awaken of the senses has been an overlooked element within our Christology yet is vital to a sense of spiritual wholeness and wellbeing, therefore a matter which must be addressed.

When considering the substantive, relational, and functional nature of the *imago Dei* it is evident that God's stamp of His personal selfhood is certifiably impressed upon humans. An understanding, and acceptance of this fact inevitably would have a significant impact on the self-worth of those experiencing EDs. However, although the capacity for reasoning as held by the traditional reformed perspective, is significantly important, by itself it is not enough to provide insight into the depths of what it means to be made in the *imago Dei.* Therefore, an embodied understanding of what it means to be made in the *imago Dei* is imperative. This perspective not only is protective against the damaging effects of dualism but also emphasizes the value of the flesh and emphasizes dignity therein, which is most apparent in the resurrection narrative. A focus on the fleshly nature on the *imago Christi* in both the incarnation and the resurrection enables women to find a voice and to make their desires known. This experience is inherently linked to erotic power (Brock, 2008; Rivera, 2015) as, being image bearers of Christ, women are encouraged to embrace the experience of being

human, openly and fearlessly, with intense joy. As healthy relationships are crucial to recovery for those experiencing EDs, a theological understanding of interrelation in the Trinity is also essential to recovery. Yet there is also an important reminder of the need to embrace divine mystery which is evident through the Holy Spirit's place in the Trinity. When considering that "rigid inaccessibility" makes the ED sufferers notoriously difficult to reach (Willner, 2009, p.16) an understanding of the non-coercive, mysterious nature of the Trinity could have a significant impact on increasing vulnerability, openness and creativity. Through women with EDs' vulnerable engagement with the incarnation through an understanding of the *imago Dei,* the pathway opens towards intimacy in mutual/right relationships and furthermore has the potential to become the catalyst for immense flourishing and creativity.

6.2.4 Creativity

The effects of trauma often nullify the potential for creative growth and furthermore pose challenges to the appropriateness and timing of the application of theological beliefs. The articulation of a response to traumatic suffering is therefore the persistent challenge of theological discourse, as one's freedom to respond to the grace of God can be demolished by the infliction of acute interpersonal trauma (Beste, 2007). As trauma disorientates one's sense of time and often violates one's body, Rambo (2010, p.155) describes it as a place where "… death haunts life and life bears death within it." By exploring and viewing the meaning of resurrection through a post-traumatic lens, Rambo links therapeutic insights and biblical narratives to portray an image of the wounded-resurrected Jesus. As Moltmann (1994, p.80) explains:

> Believing in the resurrection does not just mean assenting to a dogma and noting a historical fact. It means participating in this creative act of [God] … Resurrection is not a consoling opium, soothing us with the promise of a better world in the hereafter. It is the energy for a rebirth of this life. The hope doesn't point to another world. It is focused on the redemption of this one.

Christ identified disciples as those who were prepared, and willing, and had the creative capacity to grasp the message of His metaphorical teachings. When the disciples queried why

He spoke in parables, He explained that those who were not open would not understand the parable (Matt. 13:16-17). Therefore, he compared the lack of imagination to hardened hearts which were unable to see and hear, and theologians, as artists, in theory, should use their imaginative capacity prophetically to see and hear what others have yet failed to do. As individuals find refuge and safety within the sacred stories that give meaning to their lives, Crites (1971, p.295) explains, "[s]uch stories, and the symbolic worlds they project, are not like monuments that men behold, but like dwelling places."

In contrast to a more rigid, cognitive understanding, creativity thus permits freedom and a sense of embodied practice which engages all the senses. Smith (2013, p.17) views the imagination as "a quasi-faculty whereby we construe the world on a pre-cognitive level, on a register that is fundamentally aesthetic precisely because it is so closely tied to the body." The embodied practices of imagination help one to sense life in a manner which opens up the door to the fulfilment of the promise of God in the forthcoming redemption. The imagination is not intended as a device to escape from the present, but rather as a tool to live more fully and experience the present moment in full sensory awakening. Jones (2009, p.104) draws from Calvin's encouragement to embody the glory of God and commends using one's imaginative capacity, describing this as "faithful creativity, creativity in its truest form." Creativity in imagination and ability to think in a way which is not bound by rigidity is vital in the restoration and recovery of those experiencing EDs. Therefore, effective pastoral care inspired by the resurrection hope must emanate stability and non-judgmentalism to create enough safety to open the transitional space and sensitively and, at the appropriate time, facilitate the creative capacity of those in recovery.

There is a definitive link between creativity, intimacy, love and passionate faith – which is reflected in the call to be image bearers of God. Jones (2009, p.104) quotes Calvin's (1845) well-known metaphor "the theatre of God's glory" and comments:

> In making this reference, he suggests that when we look at the beauty and complexity of the vast world around us, we should be awed by the breadth and depth of God's beauty displayed within it. Glory is something that both God and

> the world share. God creates it, and we see it, participate in it, and hence bear it.

As one is overwhelmed by awe in this experience, there is an ability to appreciate the beauty of what was once unknown. Weil (1973, pp.164-165) explains, "... He [Christ] is really present in the universal beauty. The love of this beauty proceeds from God dwelling in our souls and goes out to God present in the universe." Being able to sense the universal and interconnected nature of this beauty is that which motivates one to love oneself, others and God as a natural emergence of authentic connection, gratitude and love. It is through this connection, gratitude and love that there is a sense of safety wherein the imagination is accessed, and creativity birthed.

Barth (1981, p.500) explains that as God's children we are "released from the seriousness of life and can and should simply play before God." As the imagination produces images and provides an active and 'playful' approach, it empowers an individual to use their imagination contemplatively (Ogden, 2014). Through contemplation on the nature of God as the playful divine creator, the individual can begin to cognitively understand and affectively grasp what it means to be an image bearer of God. Van der Kolk (2002) explains that the creative, playful use of the imagination in looking forward to future possibilities, rather than repeatedly retelling the past, is an integral part of healing from trauma. Thus, the development of creative play in the transitional space has tremendous potential for growth and change, particularly when used with those who have perfectionistic tendencies. Winnicott (1965) suggests that spending time in the transitional space one can be creatively empowered, which will symbiotically aid in identity cohesion. In this space, one can find what is sacred in a mundane story and find meaning and purpose, which leads to a sense of self within their sociocultural context (Crites, 1971). Winnicott (1971) theorises that if relationships with the world can be formed, first through transitional objects, and second, through the ability to play with others, then third, one's cultural life and heritage will become a rich and vast source of creative play. The goal of creative expression is to communicate what is unheard, to give voice to the unexpressed and to give form to what once seemed impossible. When the imaginative capacity opens, new possibilities arise. The imagination breaks through what would have been deemed impossible and can help those who have experienced trauma to

view the future with the hope they need for recovery to a full life. Further contributions to practical theology can be found in Appendix 21.

As the Christian imagination offers glimpses of God's promised redemption, hope and new possibilities can arise, leading to a more abundant life. When transitional space is opened through the repetition of culturally relevant liturgical practices, church communities can become cultural containers to restore, hold and support. As church communities open up to interdisciplinary dialogue, books, films, poetry, theatre, art and music, all potentially offer mediums by which a new identity can be created. As human consciousness mediates between the mundane and the sacred (Crites, 1971), church communities must use all the abundant resources of their tradition to provide and develop mediums which help individuals to find the sacred in their own mundane stories and thereby find meaning and purpose in their experiences. When one who has experienced immense trauma can "begin dreaming of an ordinary life" (Herman, 1992, p.155), that person is ready to begin their reintegration into a community. Providing a space where mundane stories can be shared without fear of retribution creates space to imagine and find meaning in the sacred, which will aid the individual who is suffering to transcend their social contexts and find personal meaning and identity (Crites, 1971). The creative use of the imagination in pastoral care looks forward towards future possibilities and is careful to ensure that there is not a loop of stagnant retelling of the past. Imagination and creativity are essential to the cultivation of faith otherwise biblical literalism in religious endeavour ensues and inevitable causes rigidity and stifles the potential for flourishing.

6.3. The praxis of pastoral care – Reforming present practice.

Following the practical theological response, the impact of renewed practice will be categorised into three areas: Experts-by-Experience, pastoral carers and the church community.

A definition of the three groups and the reason for the labels

Although many approaches label those who have come through traumatic experiences as 'survivors' or 'victims', these labels imply subservience and need to be reconsidered, particularly since power dynamics feature as an important theme for those who have experienced EDs. The term 'Experts-by-Experience' will be introduced to identify those who have experienced EDs. It is a term widely used in the NHS as Experts-by-Experience are currently contributing alongside specialists in mental health to contribute to the future plan for ED services in NI (HSCB, 2016).

My findings confirm that both those who have experienced EDs and their carers need more support to recover and rehabilitate than that which is currently available. The carer may be so emotionally affected, either by their experience of caring or through other issues, that they need professional support themselves. Therefore, in the initial stages, it is likely that a carer would feel more comfortable to be considered an Expert-by-Experience rather than being identified as a carer. Pastoral carers are recognised as those who have appropriate training to equip them for the task of semi-formally supporting those who have experienced EDs. The pastoral care role of the church community is open to all and is primarily addressed to those in leadership positions with the aspiration that these suggestions for renewed practice could be integrated into the body of the church community.

6.3.1 Listening

As discussed on p.66, attentive, intentional listening is one of the most positive actions when it comes to the involvement of others in recovery. Hunsinger (2011, p.17) explains "Healing begins as the traumatized begin to piece together a coherent narrative, creating a web of meaning around unspeakable events while remaining fully connected emotionally both to themselves and to their listener." Telling one's story cannot be rushed, especially when the trauma experienced may have caused an inability to find words to express oneself, therefore a sense of authentic care modelled through taking time and authentic understanding are

imperatives for recovery. Trauma specialists affirm that deliberately slowing down the process of recovery is often necessary and to corroborate the necessity of slowing down this process, almost all of those who experienced EDs recalled times when hurrying rehabilitation contributed to relapses. Doehring (2014) admits to an unskilfulness, found in some pastoral counselling, which encourages a speedy recovery through the counselee bringing all of their emotions into the open to provide a cathartic release. This approach is more likely to be damaging than helpful for those seeking help with EDs. Pastoral care should not be time-limited and should have a particular emphasis on caring for the whole person, not simply the condition. Clinebell (Clinebell and McKeever, 2011) notes the importance of being aware of the time factor as a difficulty in pastoral counselling, particularly towards the end of a series of sessions. Embracing this perspective in Christian pastoral care adds a dimension which is inspired by authentic love for the well-being of one's fellow human being. This pastoral practice is sure to help lessen fears of abandonment and communicates value and worth to the individual which is much needed in the lives of those who have experienced EDs.

Suggestions for renewed practice

Expert-by-Experience: As part of recovery, the Expert-by-Experience must give themselves the luxury of time in a non-hurried environment as this is crucial both to open the pathway to feeling and to expressing one's emotions. Furthermore, practising self-compassion is vitally important for those who have struggled with intense feelings of neurotic guilt and shame. Contemplative meditation on the compassion of Christ could be a particularly helpful aid to this practice. As the Expert-by-Experience practises sitting with their emotions through meditation, the breath, when imagined as the Holy Spirit, could also be an aid to forming an intimate relationship with God. Restructuring the evangelical practice of the 'Quiet Time', adopting aspects of Ignatian traditions and Centering Prayer may be a helpful practice to help those experiencing EDs feel safer in their bodies. As the individual begins to feel emotions which have previously been frozen, they must be aware that this is an extremely positive step on the recovery journey.

Pastoral carer: The carer must show empathy, welcoming the expression of emotions while letting go of their propensity to judge and give premature advice; this ensures that the individual feels heard, not shut down or talked over. Furthermore, assuring the one who is

suffering of utmost confidentiality, in accordance with safeguarding guidelines, decreases fear and reassures the individual that they are safe to express even the most intense emotions in the carer's presence. During this process, the carer must be aware of potential psychological projections, which may include intense anger which can arise as a defence mechanism when the sufferer is experiencing painful emotions. These emotions, which are signalling distress, must be met with skilful caring and compassion, which not only helps to diffuse anger but is also particularly useful for feelings of shame. The carer should assist the individual seeking care to sense their emotions with accuracy and to become aware of overwhelming emotions while drawing attention to the body-based reactions of these emotions. By encouraging attention to the body, through meditative practices, the destructive capacity for thought patterns to spiral out of control is reduced and thereby creates the necessary space to connect with the body before giving voice to the thoughts.

Church community: Churches can keep their members so busy that they neglect the spiritual practices of meditation, contemplation and silence. The practices of enactment and embodiment in Christian liturgy can be essential to the healthy expression of emotions and could be used in communities more often, not only as a form of worship but also as an aid to recovery (Smith, 2012). As Peedu (Evers et al., 2016, p.124) explains, "[e]motions, after all, cannot be properly expressed as verbalised statement. However, behaviours can be very emotional; behaviours can be directly motivated and effectuated by emotions, and thus one can see them as an important part of religiosity." The objective should be to create a reality where one experiences the love of God and as a result, is compelled to develop spiritual disciplines and practices to increase the intensity of this relationship. Drawing from Fredrickson's (1998, 2004) broaden-and-build theory, there is overwhelming evidence to suggest that compassion-based meditation has an impact on producing positive emotions (Fredrickson and Losada, 2005; Fredrickson et al., 2008). Arguably, then, if compassion-based forms of Christian meditation were integrated into regular practices of the church community, this could help church community members care more empathetically and also foster transformative growth and emotion regulation in those seeking care (Van Cappellen et al., 2013).

6.3.2 Wisdom

By turning to *Sophia* instead of *Logos* as a contextualised embodied symbol of the Divine Isherwood (2002, p.104) explains "*Sophia* is always involved with the people and thrives in chaos, not wishing to set in place the numbing rigidity of the disembodied word." However, although the disembodied word is rigid and legalistic, the Word is definitively creative, as is described in John (1:1; 1:14; 12:49-50). Isherwood (2002, p.103) explains:

> [a]s we have seen, feminist theologians have engaged in creative theology in order to dislodge the most oppressive aspects of the Christ symbol. This task has called for hermeneutical skill, imagination and moral courage in addition to the unshakeable belief that a more inclusive and liberating symbol may emerge from the wreckage of the patriarchal mindset.

The feminist renewal of Christology necessitates adoption of the *Sophia* tradition for Jesus and a consequent spirituality and re-framing of Jesus as the Wisdom of God.

As identified by MacIntyre (1981, 2002), in the quest towards wisdom, guidance is often sought through cognitive thought; however, in doing so, the rich insights found in embodied experience may be bypassed. McGilchrist's (2009) notable work on the right- and left-brain dynamics and psychoanalysis (Klein, 1959; Winnicott, 1965) verify that a dialectic approach is integral to human nature's quest for wisdom. "Becoming" (McGilchrist, 2009, p.233), as ongoing lived experience, exemplifies this dialectic as it embodies the cycle in which the emergence of implicit intuition is externalised. McGilchrist (2009, p.233) explains that "becoming is potential and for being to emerge from Becoming, it needs to be 'collapsed' into the present." While it is often arduous to surrender the intellectual commodities of conscious thought, the most profound sources of wisdom are those that integrate the implicit and body-based sensations. As the depths of insight and reality are found in resonation with somatic-sensory experience, work on embodied, embedded, enacted and extended cognition underpin this discussion (Rowlands, 2010).

Furthermore, when Wittgenstein (1953, 1980) emphasises the uselessness of cognitive dominance in wisdom, he illustrates how often traditional practices to incite wisdom can become intellectualised. In contrast, the embodied features of religion are colourful and

contribute in a meaningful way. Conventional paradigms of wisdom for Wittgenstein seem cold and nonsensical; rather than revealing insight, such wisdom conceals it. Sometimes intellectualisation can be used to create a pseudo-safe distance between one's emotions and one's body, thereby hindering the opportunity for embodied living. Practical wisdom dynamically connects the mind and body and thus enables one to respond to moral choices with integrity. The Aristotelian concept of *habitus* as discussed on p.69 is prescribed by Osmer (2008), Smith (2013), and MacIntyre (1981) as vital in spiritual formation. Smith (2013) understands the wisdom of *habitus* as non-cognitively connected to one's intentions. He suggests that as habits are formed affectively through bodily practices and rituals in the community, individuals should seek to relativise the role of the intellect. *Habitus* emphasises that influencing somatically-based practices as opposed to cognition are the priority, and therefore should become the focus of pastoral care for those seeking recovery from EDs.

As Campbell (in Dykstra, 2005) suggests, an imitation of the paradoxical image of the wise fool is relevant to the discussion on pastoral care. He emphasises that simple trust which produces faith is a necessary part of wisdom, explaining (p.97) that "[t]hat same simplicity can remind us that faith is a product of trust, not of reason, and that such trust comes more easily to those who do not insist on intellectualising every experience." Therefore, if the simplicity of vulnerability is key to creativity, imagination and play, this also is aligned with courage and wisdom. Wisdom cannot thrive in a rigid, closed environment, and it is evident that when the word is applied in a purely cognitive sense that this disarms its real purpose and makes it futile. Moreover, Metz (1973, p.85) argues that "[t]heology is above all concerned with direct experiences expressed in narrative language ... reasoning is not the original form of theological expression which is above all, that of narrative." Modelling authenticity, trusting in God and letting go of judgmentalism are consistently evident in wisdom narratives in both NT and OT (James 3:17; 1 Corinthians 3:18; 1 Kings 3:16-28). By moving away from abstract knowledge, *habitus* moves towards knowledge gained in the community and holistic, practical engagement in Christian faith. As Ford (2007, pp.12-13) explains, "Christian wisdom is concerned to correspond thoughtfully … to God and God's purposes, the desire for this needs to be aroused; the heart and imagination must be moved as well as the mind." Practising passionate faith must be underpinned and guided by wise

discernment. Graham (1996, p.7) describes pastoral theology as a "performative discipline." Wisdom, therefore, should focus more on right practice or transformation through action rather than efforts to increase cognitive understanding.

Suggestions for renewed practice

Expert-by-Experience: True wisdom embodies passion-filled faith and divine humility, therefore disconnects from individualistic, intellectualised notions of wisdom which are common to enlightenment values. When the Expert-by-Experience practises connecting with their body through silence, contemplative meditation and engaging with wisdom literature, this enhances the mind-body connection and, with practice, can reignite one's ability to 'sense' in an embodied manner (van der Kolk, 2012). Therefore, as one considers the possibility of finding safety in a church community, the potential arises to slow down the intrusiveness of thoughts through a deeper sense of embodiment in the liturgy of the church community. As the individual understands that wisdom is inevitably linked to the unity of one's narrative, the social construction of identity becomes shaped by the faith of the church community and wisdom becomes embodied.

Pastoral carer: The first step in acquiring wisdom requires intentional listening, wisdom requires simplicity and non-intellectualism to truly listen and hear the voice of one's soul. As Capps (Dykstra, 2005, p.118) explains, the wise fool is "… not over invested in the quest for meaning but content to let meaning arise where and when it will." Simplicity is crucial to the carer's disposition. As the pastoral carer models being able to rest in the transitory nature of a life fuelled by a passionate faith, the simplicity of wisdom becomes apparent, as does the divine nature of this empowerment. Furthermore, the wise pastoral carer will understand that appropriating spiritual truths requires patience and is not a time-limited activity nor a search for 'solutions'. The wisdom in pastoral care stands in contradistinction to that of 'medicalised activity' opening the pathway for reflection and gentle guidance rather than diagnosis and negative appraisals of behaviour. Therefore, it is necessary that the pastoral carer is one whose life, especially in interaction with the woman with an ED, embodies wise living.

Church community: MacIntyre (1981) supposes that wisdom is the most important virtue towards which one should strive. Practising virtuous acts in the community cultivates character, constructs one's identity and contributes to corporate human flourishing. As modern efforts have been more prone to divide one's life into segments, Macintyre (1981, p.190) protests that "all these separations have been achieved so that it is the distinctiveness of each and not the unity of the life of the individual who passes through those parts in terms of which we are taught to think and feel." Exercising wisdom in church communities should be a passion-filled demonstration of faith designed to empower individuals with a personal faith; an example of how this may be possible is through preaching, moving towards a Socratic method and away from a more didactic approach. The wisdom of the church community involves the creation of an environment where individuals who are suffering can be invited to re-create their identities in the community. As church communities uphold the wisdom of social construction in the community, moving away from individualistic models can provide contexts for wisdom to be cultivated, with the realisation that this cannot be cultivated quickly. It must, however, also be noted that exercising wisdom may mean a temporary withdrawal from the church as an oppressive, male-dominated institution, but it is unlikely to mean a complete separation from it, nor the total exclusion of men from women-church's discourses on faith.

6.3.3 Safety

For all of those who experienced EDs this is essential to feeling safe enough to share their story. When speaking of those who have experienced trauma Hunsinger (2011, p.21) explains "When human trust has eluded them, the traumatized desperately need an anchor, a point of reference, something or someone reliable in which to place their trust." A sense of relational connectedness as an imperative in recovery from traumatic experiences. Levine (1997) asserts that, as the sense of security in one's body develops, the capacity to form relationships increases and the heightened reactivity to perceived threat decreases. Furthermore Herman (1997) suggests that healing relationships that create safety will help with the emotional integration of past traumatic experiences and thereby aid full, embodied living in everyday life.

When considering safety in relationships it is important to reflect on the dynamics of the three persons in the Trinity. Both Moltmann (1991) and Johnson (1993) point out that the Holy Spirit has been overlooked in the Trinity and emphasis that this draws a comparison between women's oppression in the Church, and in society. Similarly, Coakley (2009, p.11) suggests that "the 'fixed' fallen differences of worldly gender are transfigured precisely by the interruptive activity of the Holy Spirit, drawing gender into Trinitarian purgation and transformation. Twoness, one might say, is divinely ambushed by Threeness." This somewhat mysterious ambush that Coakley refers to is transformative, causing a deconstruction of dualistic theological constructs through the third person of the trinity. The operational depth of this deeply passionate communion between the Three is referred to on p.82 as in Brock's (2008) description of erotic power. JI-Kim Kim (2015, p.154) explains that as the Spirit "embodies the erotic power of love and can show us how we are to live in mutuality, love, care and forgiveness." This "divine dance" (JI-Kim Kim, 2015, p.154) is mysterious and theological discourse must reflect this. As Thatcher (2014, p.47) insists, "Only by allowing ourselves to be drawn deeply into the mystery of the incarnate and risen God through contemplation and desire, can we experience something of that unknowing which constitutes the undoing of all that we know and enables us to live within the mystery." Such a position is a challenge but yet also bears significant relevance for those experiencing EDs. Considering that the need for control is a poignant part of the condition twinned with experiences of being controlled, the sense of being able to rest in the freedom of a loving friendship is imperative to recovery. Therefore, the communion of community between the three hypostases of the trinity is not only a model but also assures of the human capacity to sustain and enjoy these relationships. "[To] live within the mystery" (Thatcher, 2014, p.47) adds the challenge of embracing openness and vulnerability as further described on p.223 and is only possible through the acceptance of a non-coercive understanding of the three persons within the Trinity. Through an emphasis on the importance of interdependent relationships, the Christian doctrine of *imago Dei* becomes not only accessible through providing nurture and safety but also comforting as it challenges the traditional theological thought to contemplate human nature as contingent and contextual.

Doehring (2015) explains that spiritual practices which encourage self-compassion could help reduce the torturous feelings of shame and give meaning to one's life as part of the wider Christian story. Encouragement, not condemnation, is an important practice in all those who seek to offer care to those experiencing EDs. The effectiveness of compassion is further outlined in my findings, which suggest that being a recipient of acts of compassion, participating in acts of kindness to others or even the observation of acts of compassion are all instrumental to recovery for those with EDs. Hunsinger (1995) believes that the compassion of God becomes more than a concept when it is channelled through human interconnectedness. When considering that self-imposed social isolation is common to all who have experienced EDs, pastoral carers should give particular importance to compassion, as demonstrated through action. This is an essential part of Christian pastoral care, being described by those claiming insight definitively as "the heart of the gospel." If the traumatised individual can re-image the essence of gospel story through sensing the compassion of the pastoral carer a sense of trust in the authentic love of God is possible. Hunsinger (2011, p.19) explains,

> At its core, the cross becomes gospel for the traumatized only if they are able to see there a divine love willing to bear what is unbearable for mortal, fallen human beings. God bears for us the full weight of both sin and death. If God in Jesus Christ descends into the worst hell imaginable in order to deliver us from the hells we inflict upon one another, then such a God is worthy of our trust.

As touch and love are undeniably related in Scripture, the paucity of touch in contemporary society could be a related reason why isolation is most commonly the default reaction for those experiencing EDs. Touch expresses and effects unity and communion as one holds and learns how to and let go; these lessons are essential in developing a healthy sense of attachment. Moltmann-Wendel (1986, p.125) argues that the theology of touch has been buried by patriarchy and can be recovered. Healthy relational bonds formed in nurturing relationships are crucial for development, security and exploration. However, because of the dangers of touch when one has suffered sexual trauma it is essential to exercise special sensitivity; bonds and boundaries are vital.

Suggestions for renewed practice

Expert-by-Experience: By finding a pastoral carer or a recovery group that is part of a safe community, the Expert-by-Experience can begin to rest and feel safe in the care of other trustworthy individuals. Through the consistency of healthy relationships, fears of impending threat will start to diminish and thereby change one's perspective on trust and the reliability of others. As safety and awareness increase symbiotically, the individual's hypersensitivity, which often causes treatment dropout in secular care, can be noticed and emotion experienced rather than avoided. Commencing the journey towards fully trusting oneself, rather than focusing on individualistic efforts common to self-efficacy models, is crucial for the Expert-by-Experience, both through the development of relationships with God and other trusted individuals. Consequently, as the individual seeks help by reaching out to collaborative care structures, they can form a multi-dimensional support system which will increase their sense of safety, security and stability. Furthermore, for those who have experienced trauma, Van der Kolk (2014) explains that although there are increased levels of fear and hypervigilance there is a significant ability to sense emotions. This ability to sense could be particular useful in the pastoral care of others at an appropriate stage post recovery.

Pastoral carer: By providing a sense of safety, letting go of judgmental attitudes and cultivating a emotionally safe environment, the carer can provide stable conditions for recovery. As the carer structures time and space for pastoral care sessions, this can function as a safe container in which the individual who has experienced trauma can establish informed safe boundaries. Furthermore, through the non-judgmentalism and trustworthiness of the carer, the individual who is suffering begins to feel contained and threats of rejection begin to subside. As authenticity and honesty build trust, this helps to remind the individual seeking care of the humanity of the carer. Moreover, the carer must also consider that the timely and appropriate presentation of a sovereign God could aid some individuals in finding stability in an otherwise chaotic world.

Church community: It is essential that the church community promotes a therapeutic milieu and is an authentically safe environment to help diminish feelings of fear. Moreover, precautionary measures must be taken to ensure that those who seek to manipulate others

in the community are identified, and there are adequate measures of protection for those who are vulnerable. To establish safety for those who have experienced an ED, issues of repentance should be very carefully handled to avoid being interpreted as an unhealthy invitation to self-denigration and over-sensitivity to punishment. Furthermore, references to sinfulness that would most likely be interpreted as an attribution of blame could diminish any hope of finding safety in a church community. Rather, the church community must provide a safe container where one feels unconditionally loved and accepted. As it embodies trustworthiness and stability, reflecting the steadfastness found in the sovereignty of God, the church community provides a contextual refuge wherein recovery becomes a possibility, and the healing process can commence. By mirroring a loving God who is patient and committed to the flourishing of His people, stability is concretised and there is help available to address fears of rejection in those experiencing EDs. Through observation and experience of the faith of the committed community, the individual who is suffering can experience a sense that they too have the opportunity to trust in a benevolent God who is omnipotent, omnipresent, omniscient and committed to lovingly working on their behalf.

Daly (1993) denies the church's all-empowering potential for women and views the church as mainly an institution which has had the effect of destroying women and jeopardising women's ability to flourish. Similarly, the majority of those who experienced EDs suggested that church communities would have little to contribute to effective care for those struggling with a mental health issue. It is evident, therefore, that there is a clear distortion of the concept and image of what church communities are and of who God is (Dykstra, 2005). Daly's (1993) perceptions may be accurate, given that the majority of those I interviewed were adamant that church communities need help to change before they could hope to provide a suitable environment for those recovering from mental health issues. Fiorenza (1991) reframes the concept of church by returning to the original interpretation of *ekklesia* and its effect on community and discipleship in the early church. She explains (1991, p.15) that "[t]o link *ekklesia* or church with women makes explicit that women are church and have always been church. It asserts that women have shaped biblical religion and have the authority to do so. It insists on the understanding and vision of church as the discipleship of equals." (although many, particularly those from patriarchal stance, would deem it to exist already). Women-

church is therefore not an exclusive term with regard to men, but rather seeks to make conscious the reality of women's exclusion from ecclesial processes of decision making. Taking ownership of one's life, decision-making correlates with the necessary empowerment for women experiencing EDs, therefore the concept of women-church is particularly relevant. Using a term like women-church rather means that the traditional, patriarchal church can no longer claim to be the sole representation of church, let alone be a realisation of the dynamic reality of the *ekklesia* (Ruether, 1985). Women-church could socially construct a temporary fertile environment for safe recovery, particularly for women who have felt ostracised in the church. A formation of women-church would serve two purposes, a reconstruction of the existing church community and healing and strengthening for women who believe that recovery in church communities (in their present form) is not a realistic possibility. When church communities embrace radical regimes of equality, individuals can move from hurt to healing, through eliminating oppressive power structures and engaging in a church body of authentic love.

6.3.4 Identity

The submission of women is part of the behavioural requirements in relationship dynamics with men in fundamentalist-like communities, therefore gender inequality is closely related to identity (Bendroth,1993). Guenther (1992) confirms that when one is separated from one's stories, identity is often lost, which can be distressing and initiate a process similar to the stages of grief (Kübler-Ross, 2003). Therefore, a reconstruction of identity is essential in recovery. From a feminist perspective, relationship dynamics are by necessity equal, Heyward (in Isherwood and McEwan, 2016, p.52) explains that "[e]mpowerment is a process in which one's sense of personal identity is enlarged to include the quality of one's relationships with others in the world. In this way, being a 'person', means not simply being 'oneself' but being in relationship-to-others."

Understanding of one's identity in relation to Christ must be prominent in any attempt to ascertain precisely what the *imago Dei* is. When considering the redemptive work of Christ and the call to image Christ, Thompson (1995, p.31) makes a compelling argument for a "participative" instead of a "duplicative" approach to the concept of *imago Christi*. In relation

to the participative approach, when referring to *imago Christi*, the notion of exactly copying Jesus should be avoided as this suggests that maleness is a necessary prerequisite to imaging God rather than femaleness. This links to Brock's (2008) suggestion as described on p.214 that through refusing to see Jesus as a hero or a victim it is possible to see Jesus as an image of shared power, and thus the emphasis is on the sharing, rather than a 'once and for all' event in history. So, instead of the hero and victim categorisation, Brock (2008) Heyward (1982) and Isherwood (2004) suggest that Jesus' and our vulnerability is power in striving at just and healing relations. Therefore, the emphasis must focus on Jesus' togetherness with us through the incarnation understood "in scriptural and Chalcedonian sense as the uniquely definitive particularization of God for us in and as Jesus, which demands the surrendering of 'duplication' and thus a 'monistic' approach to the *imago Christi* tradition" (Thompson, 1995, p. 31).

In this 'participative' perspective all genders become effectively images of both Jesus' humanity and divinity. For those experiencing EDs such an understanding of the *imago Christi* tradition is inclusive and invitational and actively participatory which inevitably impacts on sense of self-worth through active involvement and purpose. As the divine image is restored and perfected in humans (as is modelled in imago Christi) the journey to wholeness, best illustrated in the resurrection narrative becomes accessible. Therefore, through an acceptance of being made in the imago of Christi has the potential to be a monumental place of hope and a momentum-provider for those who have experienced EDs as, like Christ, they have faced brokenness, immense suffering and separation, yet God divinely mandated a resurrection. As is more fully described on p.99 Moltmann (1994) explains that hope in unseen possibilities reflects the creative act of God through the resurrection of Christ. Therefore, the resurrection narrative in the imago Christi has particular relevance to the lives of those experiencing EDs as this becomes more than a matter of historical reference and more than a point of reference to a future hope, but rather an opportunity for participation in a life-giving force and healing in the here and now.

Hunsinger (1995) suggests that the pastoral counsellor can become an image of a trustworthy 'good object' to whom a woman can speak and voice her needs. This image can serve as a

reflection of the trustworthiness of God and the embodiment of selfless love thereby cultivating a safe environment to form a healthy attachment (Hall and Maltby in Bland and Strawn, 2014). Pastoral care must emphasise the need for a delicate balance of encouraging self-efficacy and room to grow, while also ensuring the safety of the individual. Just as encouragement towards self-actualisation and individuation is an important part of human flourishing, the interchange which occurs in church communities is reflected by what MacIntyre (2002, p.81) describes as "the networks of giving and receiving." Thus flourishing, and the movement towards being what MacIntyre (2002, p.81) describes as an "independent practical reasoner" and an individual in one's own right, are essentially dependent on relationships in which one can receive and give love. When considering the isolation, individualism and lack of trust exhibited by those experiencing EDs, communicating and modelling the appropriateness of natural human dependence is an important part of care. Therefore, good pastoral care must cultivate an environment where finding one's voice and hence, one's identity, is encouraged through nurturance and safety found in positive relationship in community.

Suggestions for renewed practice

Expert-by-Experience: As the Expert-by-Experience recognises the quality of their attachments and the effect that this can have on their well-being, they begin to grow in awareness. Alongside this realisation, they begin to understand that the pain encountered in grieving over the loss of even an unhealthy identity, is natural and healthy. Although learning to trust others is essential to recovery, wisdom and discernment are required to accurately sense the appropriateness of the attachment. One's attachment history functions as a groundwork for identity formation, therefore identity formation is not specifically about one's individual achievement and is more a co-construction of an individual with significant others. Silence and meditation-based practices are important as the individual seeks to self-regulate their emotional responses and begins to find themselves at home in their own bodies. Through this experience, Campbell (in Dykstra, 2005, pp.104-105) explains that one can then begin "to rejoice in the richness of the sense experience" offered by the body. As one practises non-duality, reminding oneself of the delusion of separation, the concept of being at home in and positively identified with one's body becomes a possibility.

Pastoral carer: Unhealthily-dependent relationships disable and debilitate recovery. Therefore, although providing safety is essential to the role of the carer, he or she must be careful not to practise rescuing behaviour in their bond with the individual who is suffering. Being repeatedly rescued provides a temporary pseudo-soothing effect, but it hinders the development of coping strategies. When attachments are being formed with the pastoral carer, transference can occur, which is an important tool to recovery but if the carer is unskilled, further damage can occur. The role of the carer is to cultivate new stories. Wallin (2007, p.3) states that the aim is to "deconstruct the attachment patterns of the past and to construct new ones in the present." When non-dual awareness is part of the bond between carer and the individual who is suffering, it provides a context of wisdom, security and compassion. As Bourgeault (2016, p.99) emphasises, practices such as Centering Prayer could be one of the most effective means by which to neurologically embed non-duality through "greater attention to the heart" and an "objectless awareness."

Church community: By building a secure base, church communities can provide consistency, protection and safe boundaries. In this stable base, the individual who is in recovery should be free to test boundaries without fear of retribution, as the church community exercises unconditional love and acceptance. God concepts provide an anchor for church communities both to maintain themselves with and to test their practices with the lived reality of faith in a community. Therefore, for the individual who is suffering, positive God concepts as modelled by the church community can help to reorientate the disorientating effects of a God-image crisis (Dykstra, 2005). A community environment that promotes interconnectedness and non-dual awareness could provide the optimum healing environment to cultivate a more secure sense of self. Rediscovering the *Lectio Divina* (Hall, 1988) through liturgy in church communities as a method of contemplative practice may help individuals to rest in Christ, leading to friendship, trust and love. Although there is a logical sequence to the practice, the process is experiential, unpredictable and more circular than linear, which is a marker of experiencing the affective power of the Spirit. Church communities in general can and should help to cultivate a sense of identity through consistency, a security which stabilises during the experience of turbulent emotions.

6.3.5 Hope

When reflecting on Romans 8:24, Hunsinger (2011, p.21) affirms "Though our faith holds us fast to this hope, we know that many descend into their graves with nothing but hatred toward those who have harmed them or those they love." How can hope be authentically inspired in the lives of those who have experienced EDs and their loved ones? Watts (2017) correctly states, in contrast to Snyder's (2000) self-efficacy model, hope is not wishing for nice things to happen, rather it should be viewed as a disposition which develops through spiritual practice and discipline. Similarly, Eagleton (2015) affirms that hope is indeed a disposition and not a feeling. Eagleton supports these views using Wittgenstein's (1954) perspectives which state that hope has no definitive sensation or affect, but rather the temporal structure of hope must involve language. Furthermore, Watts (2017) explains that hope is circumscribed by moral values whereas optimism is not; one should only hope for what is good. Additionally, optimism can be measured by the probability of an outcome in a way which hope cannot. Therefore, in theological discourse, although hope is a common performative verb it is one which is too often not well-understood and requires further explanation to more accurately reflect its true nature.

The humanity of Jesus in the reality of His suffering needs to be emphasised in pastoral care, not first, as a springboard to the resurrection hope, but rather as a place of apparent hopelessness. Despite the darkness of the immediate circumstances of the crucifixion narrative, hope was inherent throughout. Practically, Lyall (2001) draws attention to the fact that, in the crucifixion of Jesus, all aspects of human degradation are exposed; therefore, pastoral relationships must be approached through a deep understanding of the reality not only of human suffering, but also of the implications of death. When struggling with immense pain, many of the women interviewed commented on feelings linked to death, either wishing they were dead at certain points in their journey or through feeling as if they had a ghost-like existence. Rambo (2010, p.162) elucidates: "[i]n the aftermath of a traumatic event, practice and ways of life that people knew before trauma can never be fully recovered and restored as they once were. Instead, forms of life must now emerge with death as a shaping force." When the experience of death through the crucifixion is combined with grieving over

impending separation in the garden of Gethsemane, the helplessness and hopelessness experienced by Christ are epitomised (Matt. 26:38).

In the famous maxim from the *The Inferno*, Dante (Alighieri and Dayman, 1843, p.14) commands: "ye that are entering - all hope resign." Kalsched (2014) uses this as a paradigm to illustrate the necessity of descending into the depths with the one who is suffering, and the intense struggle with hopelessness and self-destructive forces for those who have experienced 'hellish' suffering. As Moltmann (1994) exposes the possibility of possessing Christian hope through God's presence in a personal and thus relational resurrection, he points towards the communal aspect of hope. He (1975, p.85) explains that "[n]ot the corpse that we can dissect objectively, but the body with which we identify in love, stands in the horizon of the resurrection hope. There is no meaningful hope for the body we have, but only for the body we are." The resurrection is personal for the individual, but yet communal for the body. Through letting go of the need for individualistic certainty in temporal existence and looking toward a relational embodiment, hope becomes possible.

One cannot find identity in isolation; therefore, the resurrection hope becomes visible in the collective church community. The resurrection commences with the affirmation and acceptance of the reality of suffering as Moltmann (1975, p.95) explains, "[i]n this world, resurrection happens where inexhaustible sympathy reaches the unhappy one, and he [or she] accepts his [or her] suffering." Therefore, Moltmann's resurrection hope is not to escape from the present in a fantasy of invulnerability, rather it encompasses acceptance of one's mortality in which one discovers the authentic humanity in oneself and others. Through operating from an eschatological context, Jenson explains (1977, p.113) "In historical fact and by manifest anthropological necessity, nothing but final hope ever sustains genuine suffering or enables creative historic action." Similarly, Moltmann helps individuals to view experiences not in terms of the positive potential inherent in the circumstance but rather, as discussed on p.99 Moltmann (1994) explains that hope in unseen possibilities reflects the creative act of God through the resurrection of Christ. He emphasises (1967, 1971, 1975) that this is not merely a matter of historical reference or a point of reference to a future hope, but rather an opportunity for participation in a life-giving force and healing in the here and now. He further

explains (1971, p.183) that hope recognises the influence of God's future in the present and so "makes the present historical." Consequently, hope permits the present to be seen in relationship with its denouement in the Christian eschatological narrative and so creates the sense that life is not stagnant, rather the narrative is connected and moving from one stanza to the next. Moreover, Hunsinger (2015, p.37) explains that

> [t] he biblical narrative of divine intervention – of manna in the wilderness, of angels descending with glad tidings, of prophets taken up into heaven in chariots of fire – feeds the church's imagination for all that is impossible, unreasonable and hope beyond hope, and anchors it in a ground utterly beyond its own making.

Theologically, both Moltmann (1971) and Hunsinger (2015) are emphasising that hope creates history and that a distinctive contribution of the Christian faith is the hope that it engenders in hopeless situations.

Suggestions for renewed practice

Expert-by-Experience: When the Expert-by-Experience understands their natural desire to avoid pain yet can feel the uncomfortable emotion of their own suffering with acceptance, a step forward on the journey of recovery has been taken (Kalsched, 2014; Nouwen, 1977). As the humanity of Christ and the depths of His suffering are truly understood, the individual can identify with His pain, connect with His emotions, and start to identify similarities between their narrative and the divine narrative. Further, the individual who is suffering can open the door to experiencing Christ as a fellow traveller, supported and deepened by the faith of other Christians on the journey. Moltmann (1967, p.35) explains that as hope renews faith it births a "passion for the possible." The experience of sojourning with fellow travellers thereby increases a sense of hope for the individual who is suffering. By cultivating a disposition of hope, the individual can begin to see hope in their potential to offer invaluable insights into suffering and thereby help others (Moessner, 1996; Nouwen, 1977).

Pastoral carer: The carer's primary role is embodying a disposition of hope, while being particularly vigilant that feelings of guilt and shame are not increased through careless words or behaviour. As Cook (2016, p.1) explains: "it turns out that narratives, stories, can be told and heard in importantly different ways, some of which are creative and can bring healing,

and some of which are harmful and destructive." As God's unconditional love emanates through the carer's presence and their capacity to intentionally listen and furthermore develop a 'critical friendship' through a sense of honesty; divine healing and transformation can occur. This transformation is facilitated by the carer's ability to resist expressing their own opinions, preconceptions and motives and rather simply practice the art of being present with the one who is suffering. Through listening for the soul (Stairs, 2000), the carer can embody God's presence, and become the living reminder of Christ (Nouwen, 1977), by connecting divine and human stories and cultivating the disposition of hope in the pastoral care interaction. As the carer witnesses in places of suffering, the love of Christ is embodied and channelled into a sense of visible hope.

Church community: As many of those who are suffering have little or no faith during their darkest times, they are unlikely to be able to read Scripture or pray; therefore, the support of the community through the embodiment of hope is crucial. Practising hope as a collaborative exercise encompasses the need to recognise (following Moltmann) that the possibilities and potential for hope need not be inherent in the actual situation, and rather are founded on the nature of the resurrection. Engendering hope is critical; however, this must include acceptance and the reality of suffering as the forerunner of the resurrection hope. Through the practice of intertwining the human and divine narratives, Anderson and Foley (1998) suggest that communities can experience a deeper sense of connection within the community and to God. This practice has much potential to provide hope by giving meaning and purpose to one's narrative as embedded in the community narrative; however, there is also a challenge, as it invites individuals to live peaceably with complexity and contradiction. As the communal concept of the body of Christ in contrast to the modern endorsement of the individualised self is woven through a pattern of preaching, fellowship activities and engagement with the Bible, this commences a journey of belonging. Yet this is not without awareness of the utmost necessity for sensitivity and wisdom in engagement with the bible especially when considering many of the women who have experienced EDs are also survivors of trauma. As Hunsinger (2015, p.38) explains, "[e]ach person's own life saga, when set narratively within that divine saga, gives rise to the community's hope." As the community embodies love as the foundation of hope, this socially constructs a fertile environment for safe recovery. Women-Church (Ruether, 1985) could be a particularly helpful structure for

women who have felt ostracised in the church and this could take form in pre-existing organisations such as Presbyterian Women. Women then will have the potential of moving from hurt to healing in a safe, non-judgmental environment before integration into the larger church community.

6.4 Concluding recommendations

Although a prescriptive strategy for recovery will not fit for all who experience EDs or their carers, the goal of these recommendations has been to provide the basis of material which could contribute to a programme to support informed and wise specialist pastoral care. Pattison's Critical Conversation and Osmer's first Pastoral Cycle have provided the theological methodology for this preparatory work, with the intention to continue further theological reflection. More investment into this area is crucial to facilitate a practical solution for improved pastoral care in church communities. It is evident that using these recommendations in a new methodology would require another cycle of theological reflection, which would bring about a subsequent conversation. This conversation could potentially include the pre-existing Christian testimonial literature on ED recovery and further involve specialists who could help design a theologically based programme for those experiencing EDs. The subsequent cycle could implement a recovery programme for those experiencing EDs and their carers assess its effectiveness and potentially lead to further theological reflection. Further, it is apparent that more community-based, systemic care for those experiencing EDs has the potential to be not only more cost-effective but also crucial for the recovery of the individual experiencing an ED. As Isherwood (2002, p.130) explains: "[t]hrough the power of intimate connection, individuals are carried beyond their own limitations into a greater whole, yet they remain embodied and connected with themselves and with one another. Indeed, it is the connection makes the expansion real and possible." It is evident that being part of a fundamentalist-like community is most likely to cause further subjugation for those experiencing EDs, therefore in this case the only option may be to leave the destructive community. However, it is apparent that identity cannot be found in isolation, therefore there may also be opportunity for the reconstruction of certain communities through a temporary removal from the main community in the form of women-church. In some cases, reconstruction may be possible while women are still present in the body of the

church community, however, it is essential that the core community would be receptive to change. The need to see women fully-integrated into safe communities is an imperative. It is also important to consider that although there is much importance in the reconstruction of a church communities which is empowering for women it is necessary to remember that receiving the gift of community is imperative through simply *being*. Harrison (1981, p.47) explains "Just as do-ing must be central to a feminist theology, so too be-ing and do-ing must never be treated as polarities or opposites. *Receiving* community as gift and *doing* the work of community-building are *two ways to view the same activity*. A feminist theology is not a theology of either/or." Taking all existing literature and my findings into account, there is much potential for improved pastoral care within church communities and increased collaboration between the NHS and church communities to help those experiencing EDs and their carers.

6.4.1 Potential collaboration with the NHS

Almost all of those interviewed claimed that there is only a small minority of church communities that formally collaborate with NHS in their efforts to care for those experiencing mental health issues. The majority of those who experienced EDs suggested that church communities would have little to contribute to effective care for those struggling with a mental health issue. When considering the manifestation of the Church in reality, this is evidently a distorted reflection of the body of Christ (Dykstra, 2005). Evidently, church communities need help to change before they could hope to provide a suitable environment for those recovering from EDs. Ironically, the majority of carers found a refuge in church communities and their Christian faith, however, all admitted to experiencing immense distress in their caring experience. For almost all of the carers, their distress was increased by their perception of the inadequacy of NHS services, with waiting lists, in particular, a topic of much concern. As appointments were cancelled, a sense of security was diminished and with substantial waiting times, it is evident that this causes distress in those experiencing EDs and seeking help in rehabilitation. As feminist theologians emphasise there is a necessity for women to feel valued, and with delays and cancellations in treatment due to limited resources, it is inevitable that those who have already experienced subjugation become more

intensely distressed. Almost all carers were adamant that the NHS could have done more to provide help for their loved ones. However, the majority were also adamant that the support of community-based care was crucial to the recovery of their loved one. This included group support through an ED-specific programme, The New Maudsley Method, which equips carers with the skills to support those struggling with an ED (Treasure, Smith and Crane, 2016). This, then, points to the suggestion that ED-specific programmes in church communities might be helpful to recovery and might be a potential way forward when considering implementation for change within church communities.

Economically it is evident that in NI the NHS is financially overstretched and thus often struggles to provide acute care for those struggling with mental health issues, EDs included. Practically, on the basis of the findings of this study, systemic collaboration with church communities could be an effective means of providing much-needed support for those experiencing mental health issues. I recognise that there are regulations and policies in place which would prevent the recommendation of certain religious practices as part of a method of recovery. Due to these stipulations, it may be an option for churches to provide a secularised strategy of care with an implicit theological foundation. Nevertheless, a specialised strategy designed for those experiencing EDs and based in church communities could be an invaluable resource for the NHS. In collaboration with a specialist board of professionals in psychiatry, trauma, practical theology, group dynamics and public health, the recommendations of this thesis could potentially provide foundational material to work towards a programme designed specifically for recovery from EDs. The optional opportunity of integration into a safe and mature church community could provide what feminist theologians are endorsing as an aid to the development of identity and a safe container, particularly when waiting for specialist care.

There is an obvious need for pastoral carers to be particularly cautious that Christian counselling would not interfere with specialist medical care but rather support it. One major contribution that church communities could provide is longevity, particularly in NI where, to date, there is no specialised inpatient care for those with EDs. For more than half of the

women experiencing EDs, the depersonalisation of being moved from service to service increased their distress and lowered their sense of self-worth. Church communities have potential to provide a sense of permanency both in the present and as a reminder of the eschatological hope of redemption. However, it is also evident that in light of feminist theologians' reflections, these church communities must be such that not only encourage a sense of stability but also cultivate an environment where flourishing is encouraged and indeed, almost inevitable.

Using BMI scoring (under 17.5) to assess those who qualify for specialist treatment raised particular concern for both carers and those who experienced EDs. Those who did not qualify for ED specialist care, in particular, felt unsupported and uncared for by the NHS. The computer-based CBT programme recommended for those who have experienced BN, in particular, was described as ineffective, and this is further validated by the fact that the majority of the women consider face-to-face human interaction as imperative for their recovery. It is significant, however, that more than half of those who received care from the NHS reported positive experiences, particularly in the Wellness Recovery Action Plan (WRAP) service in NI and in services that integrated art-based therapies into their care provision. The foundational strategy suggested from my findings might be helpful to supplement existing care, with the caveat of vigilance when concerning religious language and precautions against potential religious coercion. Further, in supporting effective investment, Beat (2015, p.9) recognises that an area requiring urgent further investigation includes "reviewing which treatments and interventions can enable greater levels of permanent recovery." Consequently, a valuable area for further study could include assessing the impact of care on those experiencing EDs and their carers when interventions are embedded in a church community. Once again it is inevitable that feminist theologians' perspectives on creativity come into this conversation. Although there is an innate human capacity to create and develop, when this is twinned with the spiritual, and all rigidity eliminated, there is a possibility that the individual experiencing the ED can not only recover but actually be the creator of and, indeed, expert in new forms of practice.

6.4.2 Questions for further reflection beyond the scope of this thesis

It is evident that the multi-faceted nature of the findings warrants a return to the pastoral cycle, particularly because there is much diversity of pastoral practice in different church communities. Although the findings and suggestions for renewed practice will help improve generic pastoral care especially for those experiencing EDs and other mental health difficulties, it is apparent that each individual community will require bespoke solutions.

1. What would a form of women-church look like in an NI context and could churches work collaboratively to establish a structure such as this?

2. In collaboration with a specialist board of professionals in psychiatry, trauma, practical theology, social science, group dynamics and public health, could the recommendations of this thesis provide foundational material to assist work towards a recovery programme designed specifically for those experiencing EDs and their carers?

3. How could those who are vulnerable and experiencing ED's and other mental health issues be protected against sensing religious coercion in a theologically-based recovery programme?

4. As spirituality and religion in clinical practice can be contentious among psychiatrists (Cook, 2016), could a potential programme for recovery be adapted as secular, despite being underpinned by theological principles in an effort to be more conducive to care for a wider audience?

5. Would a secular programme of recovery, underpinned theologically, be endorsed and supported by church communities, or could church communities use recovery programmes which are more transparently 'Christian'?

6. Could a theologically-based recovery programme be formally costed, developed and piloted as a randomised control trial (RCT) to a group of those experiencing an ED and their carers?

7. If the RCT were effective, how could Christian pastoral carers be trained to facilitate this programme and deliver it to groups of those experiencing mental health issues and their carers?

8. What professional relationships would need to be formed and documentation processed to formally forge bidirectional referral pathways with those offering NHS healthcare provision in NI?

9. Could guidance deriving from the findings of this thesis and the integration of a theologically based recovery programme have a dual function in helping young women with ED in recovery and furthermore help the church become a healthier body?

10. Could church communities be used to potentially offer containment as a safe holding environment for those who are recovering from other mental illnesses?

6.5 Conclusion

Although discussions on Christianity and EDs will often comment on asceticism (Bell, 2009) and suggest that the Church may be part of the problem rather than the solution, I suggest that this is a more traditional perspective relevant to historical accounts of AN. The findings from this research confirm that the Church is certainly part of the problem when it embraces the tenets of fundamentalism. If fundamentalist traits are apparent in a church community, they are off-putting and potentially damaging to those seeking care. Furthermore, as illustrated throughout the discussion chapter, fundamentalist communities mirror similar traits to those experiencing EDs which neutralises any potential for these forms of church to be a rehabilitative environment.

Conversely, the synthesis of the voices that have contributed to the recommendations of this thesis suggest that the church community could be part of the solution for those experiencing EDs and their carers if a theologically-based programme for recovery could be introduced, perhaps in systemic collaboration with specialist medical care. Further, it is important to note that this work verifies that experts-by-experience have the potential to be exceptionally gifted contributors to the life and fellowship of church communities, and through reconceiving themselves more positively as contributors and not victims, this will positively reconstruct their self-understanding. Additional investment into future research and the development of a concrete model for recovery are crucial to help the church community care

more skilfully. As increasing empirical evidence proves that greater coping expectancies for those experiencing EDs are linked to a sense of spirituality, security, connectedness, and purpose, the church community has a unique opportunity to provide a safe and loving spiritual home (Spence and Courbasson, 2012), potentially through the establishment of a women-church structure functioning through pre-existing organisations. There is undoubtedly much hope for the Church to contribute positively to rehabilitation and to help reduce relapses for those experiencing EDs. As the redemptive hope of the future "is itself the happiness of the present" (Moltmann, 1967, p.32), those experiencing EDs and their carers could find a place of rest, free from internal and external oppression, in the church community. Therefore, the promise of redemption when embodied by the church community offers not a solution per se, but rather a unique hope, inspired by Christ himself as a fellow traveller on the journey through the 'Dark Night of the Soul' and beyond.

Appendices

Appendix 1

The theory of practice

Ethnographic methods ground theological work in lived experience and in embodied ways of knowing, which points to the need for increased attention to both religious and social practices. Therefore, using the social sciences is not a surrender of the theological character of the discipline, rather it has constructed new theological thinking for contemporary ecclesiology. Rather than directly borrowing from the social sciences, Scharen and Vigen (2011) understand ethnographic practice as innately theological. Tanner reorientates theology, arguing that it is itself a cultural practice. Brown, Davaney and Tanner (2001) open up the discussion in "Converging on Culture", where they argue that interdisciplinary studies between academic theology and culture must inherently lead to TR. It is evident that, in the debate on 'ethnography and ecclesiology' and 'culture and theology,' liturgy provides "an intersection between social research methods and the field of theology" (Neiman and Haight in Scharen, 2012, p.22). Therefore, the liturgical structures that influence and shape one's thoughts and affections (Smith, 2009) are important to hold in consideration especially in the discussion section of this thesis.

Although practical theology has its genesis in applied theory, a uni-directional, deductive quality of this kind over-simplifies the reality of dialogical complexity (Lartey, 2013; Ballard and Pritchard, 2006; Hiltner, 2005). As a consequence, contemporary academics in practical theology often protest that practice and experience existed prior to theory. Having compared practical theology and pastoral theology, Pattison and Woodward (in Woodward, Pattison and Patton, 2000, p.6) find that, while they are defined differently, there are many similar features and explain that it is "probably futile to try and separate these areas either definitionally or in practice." While belief undoubtedly shapes practice, it is also evident that pastoral care itself can help people to understand doctrine more fully, as well as other aspects of the life and work of the Church.

Appendix 2

Interdisciplinary dialogue

Through adopting and adapting methods of critical correlation, interpretation, dialogue and hermeneutics, Pattison (2000) argues that practical theology must be transformative not only in the area of theory and understanding, but also in the area of practical application. He makes the point (1989, p.2) that TR is "active enquiry, not just historical research or intellectual gymnastics." Pattison's (1989) revised form of critical correlation draws on the concept that theology encompasses many divergent sources and that elements from many other disciplines can offer exceptional insight and restoration to the reservoirs of faith. Critics of this perspective have contended that if methods of TR embrace interdisciplinarity, this will automatically accommodate foreign propositions that overshadow God's truth. Thus, in writing about the relationship between qualitative enquiry and TR, Swinton and Mowat (2016) emphasise the necessity of ensuring the primacy of theological discourse. In critiquing the correlational position, they (2016, p.79) state that "if the social sciences can actually override theology on central issues, then the danger of idolatry becomes a real possibility." Therefore, they emphasise that affording the varying viewpoints an equal voice has the unhelpful potential to bring conflictual values into the conversation. However, critics of those who promote a uni-directional approach suggest that although they are the recipients of theology, they are denied the opportunity to engage with Green's (2000) invitation: "Let's Do Theology."

Alternatively, Hunsinger's (1995) approach offers a form of interdisciplinarity which prioritises the role of theology in the critical conversation, but does not diminish the role of other conversational partners. He uses the Chalcedonian pattern to establish the possibility of combining psychoanalytical insights from Jung, and in particular object relation theory, with spiritual elements of care in order to elucidate the relationship between grace and freedom. Drawing on Barth's Christological vision and ordering of the concurrence of divinity and humanity, Hunsinger (1995, p.63) offers a "bilingual approach" which compliments and uses psychological elements from a pastoral-theological perspective. Hunsinger (1995, p.10) explains the structure of the three-fold model "without separation or division [unity], without

confusion or change [differentiation], and with the conceptual priority of theology over psychology [order]." Through the Chalcedonian pattern, Hunsinger (1995) emphasises the indissoluble differentiation and inseparable unity of the human and divine nature of Christ, the ordering specifically stating that theology should have precedence. Contrary to pre-1950s thought, where the use of the Bible, history and other disciplines was more uni-directional (Miller-McLemore, 2012a), this thesis is founded on the recognition of the need for multi-directionality as part of the underpinning theological method.

Appendix 3

Hermeneutical considerations

When the "Hermeneutical Cycle" is practically applied to Scripture (Carr, 1997, p.22) and the "Pastoral Cycle" is practically applied to circumstances (Green, 1990, p.25), each consecutive method of application to the text or pastoral circumstance should be moulded by previous reflective experiences. For Carr (1997, p.22), "the dynamic interchange between text and reader" is part of the exercise of interpretation. Carr (1997, p.23) explains that to "get inside the text, [is] to become involved in the meaning" and through the process of interaction the individual is "transformed." Pattison (1994, p.2) explains that pastoral theology "is the place where religious belief, tradition and practice meet contemporary experiences, questions and actions, and conducts a dialogue which is intellectually critical and practically transforming." Steyn and Masango (2011) argue that practical theologians ought to ground their reasons for the praxis of pastoral care in a hermeneutical analysis. They suggest (2011, p.2) that

> [t]o say one should care for people in need in a pastoral way and yet not grapple with the question of why one should care at all would be somewhat presumptuous. Practical theology should therefore both prompt and sustain the following question: what is the motivation for this conviction to care?

Osmer (2008), whose contributions will feature in more depth in the pastoral care section on pp.76-86, like Browning emphasises the need for hermeneutical consideration. Osmer (2008, p.22) explains, "[a]ll interpretation begins with pre-understandings that come to us from the past." Therefore, interpretations are not impartial and objective, but rather, an interpretative process as all experience is undoubtedly affected by one's personal experience. As Graham (2017, p.177) explains:

> Practical theologians are becoming more confident in articulating their own implicit values, such as in their deployment of forms of action research in which the location and subjectivity of the researcher and a commitment to broadly transformative, collaborative and egalitarian ends are clearly stated.

Therefore, to attain integrity in TR, my transparency as a researcher has been imperative. Further, Pattison's Method of Critical Conversation has facilitated an outcome from TR; although this outcome may need continual revision, it is not simply pontificating in concentric

circles, rather it aims to move from stage to stage, building on acquired knowledge. The TR process has been deepened by consideration of the living human document, constructive narrative theology and speaking of God in public. These areas have been particularly helpful when considering how to engage practically with those in the church community, those feeling ostracised from the church community and those who may never have considered such a community as a place of refuge. Furthermore, Woodward and Pattison (2000, pp.128-29) explain that, while the academic process of TR has gathered increasing attention, one of the least developed areas is the "difference that this complex, demanding process ... make[s] in theory and in practice." The multi-directional flow is evident in the critical conversation as it becomes clear that the relationship between belief and practice is not uni-directional. Therefore, as practice influences tradition through a transformative critical conversation, this has an integrative effect not only on the person receiving care, but also on the entire church community.

Appendix 4

The Bible and practical theology

Innovative theological interpretation is an action-orientated reflective process which assesses whether or not actions are faithful manifestations of the Christian tradition. Green (1990, p.3) reflects on his motivation to write "Let's do Theology":

> The clear message was that if I managed to read, mark, learn and inwardly digest all these volumes then I too would be able to sit in smoke-filled studies and debate the various theological arguments and points of view that were being propounded there. This, they told me, was what 'doing theology' meant. But it seemed to me that they expected me to engage only in the study of other people's theology – to 'read' theology but not to 'do' it.

There has been much discussion in contemporary methods of practical theology concerning the use of the Bible in establishing how best to approach TR. For both Lyall (2001) and Browning (1991), biblical resources are valued. In validating his historical perspective on pastoral care by reference to biblical sources, Browning stands in contradistinction to Pattison (1998) who seeks to address the Bible's silent treatment of the subject. Pattison, Cooling and Cooling (2007) address the chasm between theology as an academic exercise and practical theology in an effort to improve Bible usage in Christian ministry. Cartledge (2015, p.41) writes: "[t]his chasm came about partly because of the fragmentation of theological discourse within training contexts, and partly because of the emergence of the social sciences in the caring professions, which led to a marginalisation of religious discourse." Pattison (1998, p.106) believes that "… pastoral care is largely a product of the post-biblical church." He (1998, p.107) writes about a "… frustrating peripherality" of pastoral care in the Bible itself and suggests this as one underlying reason for the confusion surrounding the Bible's use in pastoral practice. Browning (1991, p.8) admits that there is a "gulf ... between our high-level texts and courses and the practical activity of religious education, care, preaching, and worship." He posits that this bears testimony to the real extent of a divorce between theory and practice in the exercise of ministry. Lyall (2001, p.xvii) claims, "[w]hile practice is undoubtedly shaped by belief, it is also arguable that pastoral practice itself can help us to understand more fully other aspects of the life and work of the church." Lyall (2001) insists that a major part of the integrity of pastoral care is its integrating role in the life of the church;

the commitment of the entire community is imperative as pastoral care is not merely a duty reserved for the minister or formal post-holders within a congregation. This research will note how fundamentalist approaches to the Bible can be challenged in ways that are authentic to the nature of the Bible itself and to the experience of women with ED.

Appendix 5

Similarities and subtypes of AN and BN

Although AN and BN are distinctive in defining criteria, the symptoms, causes and courses of the illnesses overlap more with each other than with any other psychiatric disorder (Crow in Smolak, and Levine, 2015). Crow (in Smolak, and Levine, 2015, p.106) explains: "the critical diagnostic difference would be weight status." Heterogeneity in AN has two subtypes of predominant symptoms; that is, binge eating/purging versus restricting. For BN, there are no subtypes to explain heterogeneity, despite compelling evidence to suggest that subtypes are a significant factor in diagnosis (Wonderlich et al., 2007). The diagnosis of EDs is recognised as conflictual when considering that many clients who present with AN are susceptible to develop BN, combined with recurring comorbidity with other diagnoses such as depression and anxiety (NICE, 2017). Transdiagnostic approaches suggest that although differing EDs present particular clinical manifestations, psychopathologically they have a homogeneous core (Fairburn, 2008). Duarte, Ferreira and Pinto-Gouveia (2016) confirm that BN and AN are similar in general psychopathological presentation: in particular, self-criticism, overvaluation of body image and shame are most dominant. Fairburn (2008, p.12) suggests that "[t]his psychopathology is the over-valuation of shape and weight and their control." He advocates that all EDs should be understood as cognitive disorders and delineates core psychopathological traits which contribute to the initiation, perpetuation and maintenance of AN and BN. This will be further explained in section 3.2: Personality or temperament characteristics.

Relapse and remission

A small subset of those who experience EDs achieve remission in the preliminary phase of the illness; however, the majority struggle with symptoms episodically or chronically (APA, 2013). The chronic course of EDs is particularly evident in those experiencing AN; less than 10% experience remission in the short term, and approximately 20% remain chronically ill for the course of their lives (Smolak and Levine, 2015). Even after successful treatment, there is a high risk of relapse, especially for those experiencing AN. NICE (2017, p.40) explains "[i]t is not clear which factors reduce the risk of relapse after successful treatment, or what benefit people receive from further treatment to prevent relapse. There is also little evidence on

effective relapse prevention strategies for people in remission." BN is associated with being more episodic and may be intermittent or more chronic (APA, 2013). Approximately 30% of patients with BN remain ill for 10-20 years following presentation (Keel and Brown, 2010). As a result of these statistics, ED specialists are considering whether it may be more realistic to map the course of ED from high risk to severe enduring illness (Treasure, Stein and Maguire, 2015). It is very apparent that much research is needed specifically aimed at achieving remission and furthermore preventing relapse in those who are in remission.

Appendix 6

Susceptibility to shame

Alexithymia is a personality construct defined by a subclinical inability to describe and identify emotions and is commonly part of the psychopathology of those experiencing EDs (Westwood et al., 2017; Oldershaw et al., 2015; Barth, 2016). As verified by a large clinical sample of ED clients, traits of alexithymia are often related to traumatic experiences (Westwood et al., 2017). Due to an inability to effectively regulate emotions, when strong 'primary' emotions arise they are often suppressed. As a consequence, 'secondary' emotions arise, of which shame is the most debilitating example (Oldershaw et al., 2015). The existence of these secondary emotions may help us understand the strong emotions of shame, disgust and guilt described by women experiencing EDs when compared to healthy controls (Franzoni et al., 2013; Oldershaw et al., 2015). Persistence of these problems can add to the underdevelopment of adaptive ways to regulate emotions including self-harm (Brewer et al., 2015). Jacobson and Luik (2014) highlight that up to 72% of those who experience an ED have a history of non-suicidal self-injury (NSSI), and up to 54% of those who currently experience NSSI report ED symptomatology. Jacobson and Luik's (2014) findings are consistent with Svirko and Hawton's (2007) review of NSSI and EDs, in that the occurrence of NSSI scaled between 13.6% and 68.1% for varying types of EDs. Svirko and Hawton (2007) support this finding in stating that the high comorbidity between EDs and NSSI suggests common etiopathological factors which result from maladaptive emotion regulation.

Williamson et al. (2004) explain that the overwhelming anxiety present in the women experiencing an ED, registers as a 'feeling of fatness'; this feeling must then be evaded by purging, excessive exercise or starvation. This behaviour manifests itself in a feedback loop and by consequence further compounds feelings of shame and low self-esteem. Williamson et al. (2004, p.715) note that "in such instances, the body self-schema of the eating disorder patient is so pervasive and so powerful that it is the experiential reality of the person." Some of the schemata inherent in those who experience EDs are social isolation, subjugation, dependence and shame (Oldershaw et al., 2015). These determinants inevitably contribute to low self-worth. Many who experience EDs believe that emotions are uncontrollable and dangerous, thus unacceptable (Corstorphine, 2006). There is subsequently a resistance to

emotional expression driven by fears of rejection and criticism, even within intimate relationships (Treasure and Schmidt, 2013).

Appendix 7

Psychotherapy

Psychoanalytic treatment is known to help with emotional reactivity and the inability to self-soothe - issues that are ubiquitous among those experiencing EDs (Zerbe and Satir, 2016). The new NICE (2017) guidelines recommend ED-focused focal psychodynamic therapy (FPT) when other treatment modalities are not working. Although this treatment is much less cost-effective than CBT-ED, there is hope that it may become a more established option as a treatment modality (Egger et al., 2016). Historically, traditional psychodynamic approaches concentrated on potential subconscious motivations underlying the bodily manifestations in AN (Zerbe and Satir, 2016). Commonly those who experience EDs have a deficit in affect regulation (Vo et al., 2017). Therefore, psychoanalytic treatment is especially beneficial given its evidence-based treatment of problematic regulation of affect (Cooper, Allen et al., 2016). Zerbe and Satir (2016) suggest that psychoanalytic treatment is crucial to ascertaining what may underpin the symptoms of low self-worth, preoccupation with body weight and distortions regarding body image. Prior to FPT, IPT, as previously discussed on p.33, was used most frequently as a component of CBT treatment for those experiencing ED (Fairburn et al., 1993; Cooper, Allen et al., 2016). IPT was originally used as an intervention for depression; then in the 1980s it was modified by Fairburn (1993) for the treatment of BN. As a time-limited psychological treatment, IPT is attachment-focused and designed to pinpoint and respond to interpersonal difficulties (McIntosh et al., 2016). An adapted form of IPT is commonly used as an alternative to CBT-ED; however, the response is often slower and less pronounced (Fairburn et al., 2015). Nevertheless, flexibility and resilience are recognised outcomes of a psychoanalytic approach to ED treatment, which often results in greater self-acceptance and self-cohesion (Zerbe and Satir, 2016).

Cognitive behavioural therapy (CBT)

Guidano and Liotti (1982) propose a CBT model which centres on the belief that those who experience AN lack positive cognitive structures which relate to self-identity and lack of individuality. This was further developed by Vitousek, Watson and Wilson (1998, p.391) who argue that the essential cognitive disturbance can be interpreted as “cognitive schema disruption.” In the 1990s, Fairburn et al. (1999) conducted a sequence of treatment studies

with those experiencing EDs. Subsequently, they suggest that CBT is a worthwhile treatment intervention for over 50% of those experiencing BN.

Stemming from the impact of IPT on BN psychopathology, Fairburn et al. (1995) explain that social and interpersonal issues were particularly important in contributing to eating pathology. As a consequence of these issues, Fairburn (2008) developed CBT-E, as an enhanced method of CBT designed to more efficiently incorporate and deal with the emotional and interpersonal issues integral to EDs (CBT-ED is the derivative of CBT-E). Fairburn (2008, p.12) indicates that because AN and BN share a distinctive "core psychopathology" which has a cognitive origin, a transdiagnostic approach is appropriate. The Maudsley Model of Anorexia Treatment for Adults (MANTRA) is the more recent of the AN-specific treatments, which aims to "encourage the person to develop a 'non-anorexic identity'" (NICE, 2017, p.13). While CBT reduces ED symptoms in the short term, there is less research available relating to psychological well-being in an intermediate and long-term follow-up. Despite advances in research regarding CBT as an intervention for BN, many specialists have concerns about the large number of women relapsing or not responding to treatment (Tomba et al., 2017). Fairburn (2008, p.261), commenting on the deficits and future trajectory for CBT-E, argues that "[f]irst, the treatment needs to be made still more effective." In an effort to improve treatment effectiveness, Tomba et al. (2017) propose that further integration of an interpersonal element focused on building quality relationships that prioritise enhancing self-acceptance, is crucial to recovery.

Mindfulness-based interventions (MBIs)

MBIs for EDs reveal potential positive benefits influencing remission, particularly through the improvement of emotion regulation skills; however, more research needs to be conducted in this area (Lattimore et al., 2017). NICE (2009) recommends MBIs for the prevention of relapse following depression, and as it is recognised that depression and EDs are irrevocably linked, it is not surprising that this approach helps alleviate symptoms (Atkinson and Wade, 2015; Richards et al., 2017). The precise variety of emotion regulation difficulties in EDs is becoming more widely recognised (Harrison et al., 2010); therefore, the potential therapeutic benefits of MBIs for EDs is accumulating an empirical evidence base (Lattimore et al., 2017; Katterman et al., 2014; Baer, 2015). Results of MBIs with those who have experienced EDs suggest a

reduction in emotional distress and increased tolerance in stressful environments (Proulx, 2008). After eight weeks of mindfulness-focused therapy, Proulx (2008, p.57) explains that clients described their transformative experiences as going from "disembodiment and self-loathing to the cultivation of an inner connection with themselves resulting in greater self-awareness, acceptance, and compassion." An increasing number of studies reveal that those who experience a low level of mindfulness are more predisposed to ED behaviour (Lattimore et al., 2017). Accordingly, individuals with a high level of mindfulness were able to experience negative affect without using ED behaviour to regulate their emotions (Geller and Srikameswaran, 2015). Supported by accumulating empirical evidence, Proulx (2008, p.52) suggests; "[t]his treatment may help the 40% of women who do not improve with current therapies and might be useful to prevent symptoms in younger women." Furthermore, Cook-Cottone (2015) recommends that mindfulness-based self-care is an essential therapeutic ingredient to decrease body dissatisfaction which is the primary predictor of ED symptomology. Mindfulness practice is finding increasing empirical support from neuroscience, documenting that when meditating, the plasticity of the brain increases, giving hope for positive and lasting change (Davidson and Dahl, 2017).

Compassion-focused therapy (CFT)

Given the propensity to feel immense levels of shame, research suggests that CFT could help clients to have more self-compassion during self-evaluative threats and self-punishing attacks (Tylka, Russell and Neal, 2015). Furthermore, self-compassion can be used as a positive moderator for thinness-related pressures associated with thin-ideal internalisation and disordered eating (Tylka, Russell and Neal, 2015). There are different concepts regarding self-compassion as a treatment intervention; two of the leading proponents of academic research are Neff (2003) and Gilbert (2005, 2009). Neff (2003, p.224) describes self-compassion as being:

> open and moved by one's own suffering, experiencing feelings of caring and kindness toward oneself, taking an understanding attitude toward one's inadequacies and failures, and recognizing that one's experience is part of the common human experience.

Neff's (2003) approach is centred on the language of self-worth and encourages a change in language use; from self-esteem to self-compassion. Neff considers self-compassion to be less dependent on performance and more focused on a consistent disposition toward oneself. Gilbert's (2014) compassion-focused therapy (CFT) is a form of psychotherapy created for those who have experienced trauma and have a propensity towards self-criticism and shame. Kelly and Tasca (2016, p.721) suggest that "compassion-focused therapy approaches, which help individuals develop a more caring, sensitive attitude toward personal distress, may help to further interrupt the shame-symptom cycle." Existing research supports the theory that eating pathology and shame influence one another cyclically, and that an increase in self-compassion could help to interrupt this cyclical pattern (Kelly and Tasca, 2016; Kelly et al., 2017).

A systematic review of twenty-eight studies (Braun, Park and Gorin, 2016), offers increasing evidence to suggest an endorsement of the valuable role of self-compassion as a protective determinant in relation to body image issues and EDs. When reporting the findings from a twelve-week study, Kelly, Carter and Borairi (2014) suggested that women who develop increased levels of self-compassion in the preliminary stages of their ED treatment will have higher self-esteem and decreased feelings of inferiority and self-criticism. Furthermore, Kelly et al. (2017, p.475) report that results from a group-based CFT used as an adjunct to an evidence-based outpatient treatment for EDs, may be "an acceptable, feasible and efficacious intervention." Gilbert et al. (2014) also indicate that through developing a different method for emotion regulation, the damaging cycle that maintains the disorder could be positively interrupted. Body and image-related concerns connect to deficits in kindness to oneself, judgement of oneself and self-imposed isolation (Geller and Srikameswaran, 2015). Marta-Simões, Ferreira and Mendes (2016, p.174) argue that "self-compassion acts as a mediator between shame and body appreciation." Therefore, helping ED clients to practice self-compassion, non-judgmentalism and the development of social bonds will assist in reducing body dissatisfaction and consequential ED behaviour (Kelly et al., 2017).

Appendix 8

Fundamentalism and mental illness

With the rise of scientific rationalism and the popularisation of Freud's (1927) theories on religious belief as an immature psychological defence, there has been controversy as to whether religious fundamentalism is pathological or socially constructed. Strozier (2017, p.3) suggests that "the mindset of fundamentalism is something more deeply ingrained in the self that finds expression in a variety of human institutions, including religion but is by no means restricted to it." Understanding the social and psychological context in which fundamentalist traits take root is crucial. Schimmel (2008, p.107) explains:

> The deeper question as to why people who are intelligent and rational in many spheres of experience 'lose it' when it comes to their theology, is answered by understanding the social and psychological motives that underlie their commitment to fundamentalism in the first place.

Psychological research on religious fundamentalism has found that a simple, rigid cognitive structure underpinned by authoritarianism and orthodoxy is integral to the fundamentalist mindset (Altemeyer and Hunsberger, 1992; Strozier and Boyd, 2010). Appleby elaborates on the psychological research as he refers to the claim by Strozier et al. of those adhering to fundamentalism as having a certain pathology. A possible understanding of why fundamentalists' beliefs are militantly reactive is grounded in the understanding that their response is a natural psychological reaction to threat or an outworking of the effects of trauma. Further, Inozu, Koranic and Clark (2012, p.959) suggest that "certain cultural experiences such as adherence to religious beliefs about the importance of maintaining strict mental control might increase the propensity for obsessional symptoms." In a more recent article, Strozier (2017) expands upon these obsessional traits and suggests that the trait of paranoia, and the intensity which often comes alongside it, is distinctive of those involved in fundamentalist movements. Stein (2003, p.43) explains:

> Fundamentalism, seen in terms of psychic mechanisms, can be described as an extreme manifestation of the paranoid-schizoid mode, where persons operate with constant splitting and projective identification to externalize and concretize

> persecutory and idealized inner objects. This mode explains both the cognitive 'simplicity' and the extreme emotions found in fundamentalism.

Although there are arguments to suggest that fundamentalists come from a background of low education (Saroglou, 2016) and their propensity toward dualistic processing implies cognitive simplicity (Stein, 2003), there is compelling evidence to suggest that many are gifted, but psychologically troubled, individuals (Strozier, 2017).

Although Appleby (2015, p.46) is adamant that fundamentalists exhibit "symptoms of a mental disorder" Bruce (2000) argues that, rather than being pathological, fundamentalism is a rational response that formulates a cultural defence which unites against an external threat. Frey and Berger (2010, p.4) clarify the rationale for this position: "[f]undamentalism is the attempt to restore or create anew a taken-for-granted body of beliefs and values." This vehemence is often supported by a supposedly special eschatological insight. As Maltby (2013, p.183) explains, "[a] fundamentalist theology that claims knowledge of the transcendent, that claims intelligence of a providential scheme of salvation, is more likely to think of itself as authorized to insist on a particular kind of belief." The authoritarian traits within fundamentalists could be compared to a narcissistic personality; however, it is important to consider the social construction of these traits in a certain context. When dealing with fundamentalist clients in clinical settings, Aten, O'Grady and Worthington (2013, p.80) insist that "[a]lthough many fundamentalists will strike some outsiders as paranoid, narcissistic, or compulsive, clinicians should consider the social context as well as within-group differences when making diagnoses." Although there is evidence to suggest that there are pathological factors to consider in fundamentalists' behaviour, as Aten, O'Grady and Worthington (2013) suggest, caution is required before any judgements are made, as the social context is of particular importance.

Appendix 9

Social constructionism

Social constructionists suggest that how one comprehends and incarnates the world is specifically influenced by history and culture (Berger and Luckmann, 1967). This research assumes that reality is socially constructed in a multitude of ways which acquire meaning as it is explored. Crotty (1998, p.47) explains: "[w]hat constructionism drives home unambiguously is that there is no true or valid interpretation." As social constructionism is based on an anti-essentialist position, its character is not pre-determined, therefore it functions from the perspective that humans do not have fixed characteristics and are therefore open to construction.

In qualitative research, the social constructionist method focuses on three relationships; the researcher's rapport with the interviewees, the readers of the research, and society at large (Given, 2008). Consequently, it is important to acknowledge that interpretations are not constructed in solitude but against a setting of shared and divergent understandings, traditions, identities, practices and language (Schwandt, 2000). The ways that individuals cognitively and behaviourally comprehend the happenings, structures and interactions of everyday life and the social world that confront them, is of specific interest in social constructionism. Moreover, because different comprehensions of the world lead to divergent social actions, the social construction of knowledge therefore has social repercussions (Burr, 2015).

Liamputtong and Ezzy (2005, p.132) explain that the social constructionist perspective is founded on the precept that all "narratives sit at the intersection of history, biography, and society." Denzin and Lincoln (2003, p.24) assert that social constructionism demands that the exploration of the research question be "filtered through the lenses of language, gender, social class, race, and ethnicity" of both client and researcher. In a social milieu, those who embrace social constructionism believe that culture shapes the way in which the lens of perception is constructed; therefore, it has been particularly important to be attentive to this epistemology during data collection and when formulating the recommendations of this thesis (Crotty, 1998). The inter-subjectivity of reality would seem dependent on social

processes; it is essential that this be considered when suggesting church communities could have a role in forming a rehabilitative environment for those experiencing EDs.

Post-structuralism

A focus on the words used in the narratives of those interviewed for this research has been inevitable in the analysis of the data. Burr (2015, p.64) explains that "if language is the place where identities are built, maintained and challenged, then this also means that language is the crucible of change, both personal and social." It must also be noticed, however, that such power relationships might be underpinned by coercion which is not primarily identified as being linguistic. Fredrickson and Roberts (1997) propose that their "objectification theory" explores the social discourse that establishes the bodies of women as objects to be observed and impacts negatively on the body experiences and sense of self of women. Furthermore, when considering issues of self-objectification in women experiencing EDs, Foucault's (1977) theories on discipline, self-regulation and self-surveillance have been relevant, as these are deemed the new mechanisms of social control in contemporary society. In "The social construction of anorexia nervosa" Hepworth (1999) critically examines EDs and affirms that post-structuralist theories are relevant to the socially constructed sense of self for those experiencing EDs. The sense of self or temporal identity is an ever-changing social construction influenced by its context and thus one's environment is all-important to recovery (Berger and Luckmann, 1967). The potential for transformation and recovery through a reconstruction of language is therefore possible.

Appendix 10

Exploratory research

Robson (2002, p.59) suggests that an exploratory research intends to assess "what is happening; to seek new insights; to ask questions and to assess the phenomena in a new light." Gray (2013) also explains that an explanatory research aims to uncover the causal relationships between variables. Conversely, exploratory research is used for research problems which have not been clearly defined and therefore it is often used before there is enough information to suggest an explanatory relationship. Schutt (2011, p.11) writes that social exploratory research:

> seeks to find out how people get along in the setting under question, what meanings they give to their actions, and what issues concern them. The goal is to learn 'what is going on here?' and to investigate social phenomena without explicit expectations.

Mayring (2000) suggests that explorative qualitative social research is turning into an interdisciplinary point of reference. Social work and practical theology are working together to conduct an exploratory conversation in this project. Denzin and Lincoln (2003, p.651) deem such interdisciplinary efforts in narrative research as a "field in the making." Ghiloni (2013, p.18) writes: "theologians can be heartened that the goal of interdisciplinary work is not to provide conclusive answers, but to initiate and enrich ongoing conversation between diverse groups."

Qualitative research

Given the emphasis on striving for depth of understanding to interpret contexts, behaviours and interrelations, Alvesson and Deetz (2000, p.1) suggest that:

> [q]ualitative research has become associated with many different theoretical perspectives, but it is typically oriented to the inductive study of socially constructed reality, focusing on meanings, ideas and practices, taking the native's point of view seriously.

Furthermore, one of the main advantages of qualitative research is its potential to create knowledge about complex relationships and new phenomena which have not yet been researched thoroughly or at all. Although qualitative research may be deemed to generate generalised descriptions of a phenomenon, it has permitted the interviewees' diversity to emerge. When this data was aligned with existing literature it revealed reoccurring themes. For a narrative as personal as that relating to an ED linked with religious experience, commentary on the idiosyncrasies of each individual's account has been a crucial adjunct to the description of the general experience.

Semi-structured interviewing

Willig and Stainton-Rodgers (2017, p.364) suggests that in the semi-structured interview a trigger word should be used which is "(any word associated with embodiment) as a way of generating subjective material." Although the un-structured element of the interviews was particularly liberating, the pre-scheduled questions also proved significantly effective in the analysis, when observing contrasts and comparisons between narratives. Brewin, Andrews, and Gotlib, (1993) suggest retrospective recall is improved through the use of the semi-structured interview method, as one's memory for temporal details of experiences may be enhanced. However, it must be noted that qualitative interviews normally rely on the interviewee's ability to verbalise, remember and conceptualise (Mason, 2002). Mason (2002) and Silverman (2016) warn of the epistemological implications of semi-structured interviews in that they do not reproduce realities.

Appendix 11

Interview questions for ED clients

According to the principles of qualitative research, the interview schedule will not be predetermined. It will be semi-structured, in that the interviewer will have selected certain topics as of likely importance, however the interviewee will be given the opportunity to respond to or ignore questions as he sees appropriate. Further information will be sought by the use of clarifying questions where necessary.

Personal Experience: Past Journey.

Purpose of Data	**Main Questions**	**Clarifying Questions**
External stimulus/ behaviour	1. Can you tell me how and why you think your ED started?	What age were you when it started? Why do you think it started? What was happening in your life at the time?
External stimulus/ behaviour	2. When your ED started were you living on your own or with your family or friends?	Could you describe your home circumstances at this time? Could you describe your family and friends at this time?
External stimulus/ emotions	3. What were the emotions you experienced in your social/family relationships in the past?	Was there any relationship dynamic in particular which caused emotional intensity in your experience? If so, could you explain this? Do you think these relationships played any negative or positive part in having an ED? If so how?
Emotions/ behaviour	4. When your ED was at its most severe could you describe the emotions you experienced?	Did the ED alleviate distressing emotions, add to distressing emotions or both? Why do you think this is the case?
Emotions/ behaviour	5. What words and phrases would you have used to describe yourself when your experience of having an ED was at its most severe?	At this time were you able to understand the difference between your feelings and your thoughts? In the past would you have found that your thoughts flowed into your mind gently and controlled or would you have described this as a more forceful and out of control?

External stimulus/ behaviour	6. Were there any other mental health issues or physical issues which were prevalent during your experience of having an ED?	Do you think these had an influence on your rehabilitation? Did you ever struggle with any other addictive behaviour alongside or at a different time to the ED? If this is the case, why do you think you adopted this additional or alternative behaviour?
External stimulus/ behaviour	7. What type of events/experiences would have made your ED worse?	Could you describe what way you coped with these experiences in the past? Why do you think you responded to stressful situations like this? Would you have described your behaviour as involuntary or did you feel as if you had a choice?
External stimulus/ emotions/ behaviour	8. In the past could you describe the most positive actions taken by those caring for you which aided in your rehabilitation?	What support systems e.g ED NI, GP etc. have you availed of in the past in relation to the ED? How do you believe these affected your rehabilitation? What's the difference between these?
External stimulus/ emotions/ behaviour	9. In the past could you describe the most negative actions taken by those caring for you which hindered your rehabilitation?	Why do you think this was the case? Can you give an explanation?

Personal Experience: Recent Past/Present Journey

Purpose of Data	**Main Question**	**Clarifying Questions**
Emotions/ behaviour	10. Can you tell me how 'normal' you would consider your eating patterns to be at present?	Have your eating problems changed over time? Would you consider yourself to have fitted into categories of anorexia/bulimia/ENDOS at different times? Have there ever been any period/s of relapse? How do you feel about your relationship to food now?
Emotions/ behaviour	11. If you have recovered or are recovering physically from your ED do you still	What emotions would you frequently feel? How often would you now cope with distressing emotions? Would still feel like you

	have any difficulties with distressing emotions?	want to manage these emotions through an ED?
External stimulus/ emotions	12. If you experience any distressing emotions, could you describe an experience or experiences which gives rise to these emotions?	Do these experiences happen often in your life? Would you feel that you react more or less emotionally to these experiences than other people? Why do you think this is the case?
Emotions/ behaviour	13. If you do experience any distressing emotions, how do you cope?	Do any particular practices make these emotions more distressing? If so could you describe what you do? Does speaking to anyone in particular make these emotions less distressing? If so what would you consider to be characteristics this person has which helps alleviate the distress?
Emotions/ behaviour	14. How do you feel about being alone?	Are your emotions and thoughts different or the same when alone and when you are with others? Do you find it easy or difficult to relax? What is it about being alone that you like or dislike?
Emotions/ behaviour	15. Can you describe how you think your ED affects/has affected your relationships with other people? i.e. Partner, family, friends, work colleagues?	Why do you think this is the case? Have your relationships with others changed as your relationship to food has changed? Would you find social interaction easy or difficult? Why do you think this is the case? Would you be more prone to trust or distrust people who are in your life? Why do you think this is the case?
Emotions/ behaviour	16. What words and phrases would you use to describe yourself as a person?	Could you guess percentage wise how much of the time is spent telling yourself positive stories? Could you guess percentage wise how much of the time is spent telling yourself negative stories? Are you able to create a distinction between your feelings and your thoughts?
Emotions/ behaviour	17. What is your perception of how other people think about you?	What type of person do they think you are? Have other people ever told you what they think of you, could you give a negative and a positive example?

External stimulus/ emotions/ behaviour	18.Could you explain how 'you' stop negative thought patterns?	Would you find that your thoughts flow into your mind gently and non invasively or would you describe this as a more forceful and invasive? Do the negative thought patterns return or once you stop them are they resolved forever? Are the concerns usually about the present, the past or the future?

Personal experience: Religiosity or spirituality

Purpose of Data	**Main Question**	**Clarifying Questions**
Emotions/ behaviour	19. Can you tell me a little bit about your childhood religious experiences?	Did you grow up going regularly to church? Were your parents/carers affiliated with a church? What denomination was this? Was this something you considered enjoyable or not enjoyable and why?
External stimulus/ emotions/ behaviour	20. Can you describe your spirituality or religiosity?	Did this come about through what you would describe as a spiritual experience or through the decision to make a commitment to a religious community? Was this suddenly or did it happen gradually? What were the events surrounding this belief? What way did this make you feel? Do you remember the thoughts you had at this time? Have the emotions and thoughts you have when reflecting about this experience changed over time?
Emotions/ behaviour	21. Did you ever approach a church community or someone affiliated with a church for help with your ED?	Can you describe the process and reasoning behind approaching someone affiliated with a church or attending a community? Could you describe briefly your religious journey as regards to churches including changing communities and if so, why this was the case? If you were/are involved in a religious community do you believe this has had any influence on your eating patterns in the past or at present?
Emotions/ behaviour	22. Could you describe in your understanding the role of being a woman within a church community?	Are there any difference between the roles of women and men within the church community you are referring to? Do you believe the church you are referring to treat woman and men as capable of the same roles? Why do you think this is the case?

Emotions/ behaviour	23. Emotionally how would you describe the experience of care you have received in church? If multiple experiences please describe.	How did those who had intentions to care make efforts to soothe you or reassure you? To what extent did you feel that they understood your distress? Did they spend more time offering advice or listening or equal amounts of both? What adjectives would you use to describe how they listened to your story? What kind of advice did they offer?
External stimulus/ emotions/ behaviour	24. How did/do you believe participation in church community has helped to aid in or has detracted from your personal rehabilitation from an ED?	Could you describe this collective experience of care in Christian community? Does/did participating 'communally' in a church community's practices such as worship, prayer, scriptural reading, meditation help to make you feel more peaceful or less peaceful? Why do you think this is/was?

Personal experience: Pastoral care

Purpose of Data	**Main Questions**	**Clarifying Questions**
External stimulus/ emotions	25. When talking with a Christian pastoral carer or member of the church community were you confident that they understood the emotions, thoughts and behaviour involved in having an ED?	What did they say or not say to make this apparent and how did you feel about this? Were you confident that they had a skill set which could aid in helping you? Would you say that they were more focused on helping you to talk about the past or to adopt tools to cope with your emotions/behaviour or both? What helped you the most?
External stimulus/ emotions	26. How soothing did you find the language used by the pastoral carer or church community member, did you feel it was helpful in your rehabilitation?	Was there any religious language used in the care received? Was this helpful? Are there any words or phrases that springs to mind which were significantly positive in the consultation? Are there any words or phrases that springs to mind which were significantly negative in the consultation?
External stimulus/ emotions	27. Did you feel as if there were any conditions to the care you received from the church community	Were there any suggestions made by the pastoral carer to join a Christian community? If so how did this make you feel? Were there any suggestions made as regards to committing to a Christian belief in God through what was said

	member or pastoral carer?	in the care giving experience? If so how did this make you feel?
External stimulus/ emotions	28. How would describe the character of the person who offered care?	Were there any observable traits in their character which made the care more or less effective? Did you trust them easily or did you distrust them? Would you say you felt as if this person was non-judgmental or judgmental? From your experience did you feel the carer was compassionate? Could you explain this?
Emotions/ behaviour	29. Were any spiritual exercises such as prayer, meditation, silence and solitude, journaling and learning, evangelism or worship suggested by the carer?	Did you find these useful? Were there any suggestions or advice given which you struggled with? At the moment, if you are unhappy, do you presently use these practices to soothe yourself from uncomfortable emotions? If not what do you do when you experience uncomfortable emotions?
Emotions/ behaviour	30. Thinking back to the time period after receiving pastoral care could you recall what emotions you felt and the thoughts that entered your mind after the consultation?	Was there the offer of more consultations or was this an isolated event? How did you feel about this? After your experience of pastoral care in church do you feel your thought patterns have changed? Could you describe this experience? What was the most positive and most negative elements in reflection upon this care?
External stimulus/ emotions/ behaviour	31.When you consider support systems as a whole what would you consider to have been the most effective for you?	In your experience what was the difference between the care you received in the health service and Christian pastoral care? In your experience is there a difference between how the church and the health service in their expertise and ability to help you to understand your feelings and think about why you were upset?
External Stimulus/ Emotions/ Behaviour	32. In your experience was there any cross network or pathways of referral between the health service and the church?	Could you describe why these systems best worked for you and what was the least helpful? What way did this help make you feel and how did it affect your experience of having an ED? In retrospect what do you think could have helped more?

Conclusion of Interview	33.Thank you for your time. Do you have any questions that you would like to ask of me?	

Appendix 12

Interview questions for past or present carers of women who have experienced or are experiencing EDs

According to the principles of qualitative research, the interview schedule will not be predetermined. It will be semi-structured, in that the interviewer will have selected certain topics as of likely importance, however the interviewee will be given the opportunity to respond to or ignore questions as he sees appropriate. Further information will be sought by the use of clarifying questions where necessary.

Initial signs of illness

Purpose of Data	**Main Questions**	**Clarifying Questions**
External stimulus/ emotions	1. Can you remember how the ED started?	In your opinion was there any particular event or events which may have initially contributed to the ED? What was the age of the client under your care when the ED started?
External stimulus/ emotions	2. How would you describe the home environment of the client under your care prior to the ED?	How would you describe the friendship circles of the client prior to the ED? In your opinion what were the emotions present in the client at this time?
Emotions/ behaviour	3 When you first realised the client under your care was struggling emotionally, was there any change in the words and phrases she used about herself?	Can you describe this change? Did she change in the way she spoke about others? Was there any other noticeable behaviour which changed?
Emotions/ behaviour	4. Would you say she became more socially involved or more withdrawn in these initial stages or was this cyclical?	If so, what do you think caused these cycles? In conversations would you say the client under your care was present or did she appear to be more vacant? Did you notice any other changes in her social involvement, activities, circle of friends, and relationships with family or partner? In your observation was she aware of these changes?

Emotions/ behaviour	5. How did you respond or react to your client's change of mood eg. what did you say and do?	Do you believe this was helpful or unhelpful or both? Could you describe your awareness of the actual behaviour which confirmed to you she had an ED?

Journey of ED

External stimulus/ emotions	6. Would you say that the type of ED changed over time?	Was the client under your care bulimic, anorexic or would you consider her to have adopted both of these types of EDs?
External stimulus/ emotions	7. Were there any circumstances, experiences which raised the emotions and aggravated the ED of the client under your care?	Was there something integral to the character of certain people involved in negative circumstances which had a negative effect? What was it? Why do you think this was the case?
External stimulus/ emotions	8.Were there any circumstances, experiences which helped to soothe the client under your care when distressed?	Was there something integral to the character of certain people involved in these experiences which had a positive effect? What was it? Why do you think this was the case?
External stimulus/ emotions	9. Under your observation what were the emotions most frequently experienced by the client under your care?	In your observation would you describe these emotions as intense or normal? Did the emotions last for long periods or did they vary in accord to the circumstances? Could you describe this?
Emotions/ behaviour	10. In your observation could you describe the behaviour of the client related to the ED?	What was the frequency of the behaviour? Did the frequency of abnormal behaviour increase in line with life circumstance? Could you describe this?
Emotions/ behaviour	11. Did the client under your care talk about her ED?	If she did what she say? Do you believe the client under your care's awareness of your emotions affected the ED negatively or positively?

Emotions/ behaviour	12. How did you respond/react if or when your client opened up about her ED?	What way did you feel about this at the time? What words, phrases and behaviour did you use in response to these emotions?

Help seeking

External stimulus/ emotions	13. Were there any events experiences which prompted help seeking in your opinion?	Were there any pattern or observable triggers for help seeking? For example after a life disappointment such as a relationship break-up, exam results or a dispute with friends?
Emotions/ behaviour	14. As a carer was there anything you felt you could do to encourage or prompt the client under your care to seek help?	Were there any words and phrases you could use or other behaviour which helped the help-seeking process? Were there any words and phrases you could use or other behaviour which hindered the help-seeking process?
Emotions/ behaviour	15. At this time of help seeking what would you have considered to be the emotions were prevalent in the client?	Would you describe the client under your care at this time as resilient or vulnerable? What was her body language like at this time?
Emotions/ behaviour	16. How did she initially approach you for help, what was her behaviour, notable words and phrases used?	In this help seeking process was the client open about her emotions and thoughts? In your observation was she able to differentiate between her thoughts and emotions?
External stimulus/ emotions/ behaviour	17. What words, phrases and behaviour did you use in response to your client's help seeking?	Could you recall what you believed to be helpful and what you believed to be unhelpful in your behaviour at this time? What words, phrases and tone would you say she responded negatively to? What words, phrases and tone would you say she responded positively to?

External stimulus/ emotions/ behaviour	18. Has there been any relapse? If so, could you describe this experience?	Why do you think this happened? If there has been relapse in your opinion did the client under your care's mood change rapidly or was it more slow and gradual as relapse occurred? How long did this episode last?
External stimulus/ emotions	19. As a carer how did or do you support the client under your care?	What have you found to be the best rapport builder for you and the client in your care? Would there be any activities in which resulted in reduced distress in your client?

Church community involvement

External stimulus/ emotions	20. What did you observe as regards to the client in your client's involvement within church community?	What were the circumstance surrounding the client becoming involved in a church community? Did the church involvement start gradually and increase or did it happen suddenly? What was the extent of the involvement? How frequently did she attend meetings or meet with people from the church?
External stimulus/ emotions	21.In your observation what was it about involvement in a church community which attracted the client under your care?	When involvement occurred were there any people involved who encouraged this involvement or was it an independent decision? Could you describe this process?
Emotions/ behaviour	22.Was there a change in her language about herself subsequent to being involved in church community? Could you describe this change?	Was there a change in her behaviour subsequent to being involved in church community? Could you describe this change? Did this change stay consistent? If not how did you know it didn't stay consistent and why do you think it changed?
Emotions/ behaviour	23. Were any spiritual exercises such as prayer, meditation, silence and solitude, journaling and learning, evangelism or worship suggested by the carer which helped with your clients rehabilitation?	In your opinion why did this help? Were these communal or private practices? Did you ever use these practices with your client?

	Were any spiritual exercises such as prayer, meditation, silence and solitude, journaling and learning, evangelism or worship suggested by the carer which was unhelpful with your clients rehabilitation?	In your opinion why did this not help? Were these communal or private practices? Why did you feel this was the case with your client?
External stimulus/ emotions/ behaviour	24.Was there a specific ED related care offered to your client when she approached a church community?	In your opinion are church communities adequately informed and equipped to care for those with EDs? Why or why not?
External stimulus/ emotions/ behaviour	25.In your opinion can church communities contribute positively to the rehabilitation of clients with EDs?	What do you see as the difference between church communities, statutory services and charity based groups when considering the care of those with EDs? Which is the most effective in your opinion?
External stimulus/ emotions/ behaviour	26.In your experience is there adequate collaboration of care between specialised medical professionals and church communities?	Could you describe what type of involvement would be most beneficial in your opinion? Do you think church communities could do more to help clients with EDs? If so how?
Conclusion of interview	27. Thank you for your time. Do you have any questions that you would like to ask of me?	

Appendix 13

Interview questions for church community members.

According to the principles of qualitative research, the interview schedule will not be predetermined. It will be semi-structured, in that the interviewer will have selected certain topics as of likely importance, however the interviewee will be given the opportunity to respond to or ignore questions as he or she sees appropriate. Further information will be sought by the use of clarifying questions where necessary.

Background knowledge of eating disorders

Purpose of Data	**Main Questions**	**Clarifying/Expansive Questions**
External stimulus/ emotions/ behaviour	1. Do you have any knowledge as to how an eating disorder (ED) can start?	What emotions are commonly present in ED clients prior to the adoption of an ED? What are some of the external circumstances which have been recognized to lead to an eating disorder?
Behaviour/ emotions	2. How would you describe the behaviour of and emotions experienced by women with an ED?	Do you have any knowledge as to how an ED can develop and perpetuate? Do you believe an ED affects an individual's ability to function socially? How would you believe an ED affects bonds with family, partners and friends?
External stimulus/ emotions/ behaviour	3. In your personal experience or through acquired knowledge what emotions are experienced by the family of the client struggling with an ED?	Does the behavioural response of the family impact the individual with the EDs? If so, how? How would you respond to the statement that an ED is socially constructed?
External stimulus/ emotions/ behaviour	4.Would you say that your church would adhere more to a medical model of therapy for ED clients or a behavioral model?	Many ED clients are on medication for other mental health issues such as depression, how is this understood in your church community? If you adhere to the behavioural model, how would you see church community as being a helpful aid the re-conditioning of the woman struggling with an ED?

External stimulus/ emotions/ behaviour	5. Could you provide any theologically relevant or church related historical examples of females who had eating related problems?	In your opinion are there any theological links between hunger and fasting to EDs? Why do you think there have been reports of anorexic women in the church for centuries?

Church community perspective

External stimulus/ emotions/ behaviour	6. Are you aware of any stigma associated with EDs or other mental health concerns in church communities?	How do you think mental health issues could be further de-stigmatised in church communities? Do you think it's easy or difficult for people to talk about mental health concerns in church communities? Could you explain what emotions may be prevalent in this?
External stimulus/ emotions/ behaviour	7. How is your Christian community collectively involved in pastoral care?	What do you believe to be the facilitating factors of and hindrances to care in the larger christian community? How is pastoral care in the wider church community different from interactions with individual pastoral carers? Is there a structured pathway of care between the larger Christian community and of individual sessions of pastoral care?
Emotions/ behaviour	8.What communal practices are important to the spiritual health of the church community?	Why is this the case? do you believe the practices in Christian church community could help the rehabilitation of a woman struggling with an ED? Is there anything in Christian church community which could hinder the rehabilitation of a wonan struggling with an ED?
Emotions/ behaviour	9. In your knowledge is it common for women with EDs to disclose their disorder to a member of the church community?	If not disclosed by the client, what would be the protocol for dealing with a woman with an ED when aware of observable signs within your church community? Is there anything you know of within church communities which may hinder the help seeking process?
External stimulus/ emotions/ behaviour	10. Has your church community had any training on issues concerning EDs or related mental health issues and how to care for those struggling with this concern? If so could you describe this training?	If so, what organisation/or from whom has this training been obtained and how was it disseminated amongst the community? Do you believe more awareness is a necessity for the church community to better respond to these concerns? Would more training be helpful specifying in particular disorders for the entire community or for pastoral carers? How?

External stimulus/ emotions/ behaviour	11. How does your church work in collaboration with the relevant sectors of the NHS in referring clients for specialist care?	If there is collaboration, could you describe the pathways between your church community and the NHS? Should this collaborative relationship be different in your opinion? If so how?
External stimulus/ emotions/ behaviour	12. What would you consider to be the unique contribution of your church community to the rehabilitation of women with EDs?	Would you consider the church to provide a suitable environment for rehabilitation from negative cultural influences for women with EDs? Do you see any evidence of secular cultural influence within the church? In this negative or positive in your opinion?
External stimulus/ emotions/ behaviour	13. Within your church community could you describe how there is a recognition of the differences between males and females in : (a) Church community roles (b) Hierarchical delineation (c) Personality	Are females within the Christian community with which you are affiliated cared for differently than men? Do men commonly assist in a caring role within the church? If not why not? Do you believe that church hierarchy empowers or disempowers women in your church? Could you explain this? Was this always the case in your church?
External stimulus/ emotions/ behaviour	14. How does a person go about joining your Christian community? How might this process make allowances for people who are emotionally vulnerable?	How does your church identify those whom it may identify as emotionally vulnerable when these individuals are considering joining the community? Is there a process prior to initiation into a community or is this left to the discretion of the individual?

Pastoral care

External stimulus/ emotions/ behaviour	15. What would be the protocol for consultations of pastoral care within your church when dealing with a client with an ED?	Would the pastoral care team within you church approach someone who you believed to be struggling with an ED (or mental health issue) without an invitation for help? Would there be a formalised structure to pastoral care sessions? Are there a team of specialists within your church do deal with specific concerns?

Emotions/ behaviour	16. How would you describe the role of : (a) spiritual direction, (b) reflective listening, within pastoral care?	Percentage wise how much time within sessions of pastoral care would be devoted to listening? How much time within spiritual direction? What other ways is the time in consultation spent? What do you believe is the most effective format of pastoral care to facilitate change in behaviour?
Emotions/ behaviour	17. When engaging in pastoral care, is any religious language used in order to communicate to the client?	Would religious words such as faith, belief, sin, forgiveness, healing, demons, repenting saved and lost be used in the practice of pastoral care? Do you believe these words are appropriately understood by those receiving pastoral care?
Emotions/ behaviour	18. When engaging in pastoral care are there any religious practices used or suggested when communicating with the client?	How in your experience have clients responded to this? Could you explain how you believe these practices may or may not help women with an ED? What place do religious practices have in the community as a whole?
Emotions/ behaviour	19. How would your church seek to address the emotions of guilt, shame and fear through the practice of pastoral care?	Are there any forms of religion related behaviour which could exacerbate these emotions in your opinion? Are there any forms of religion related behaviour which could ease the intensity of these emotions in your opinion?
External stimulus/ emotions/ behaviour	20. How is the concept of faith used within the context of pastoral care when considering an individual presenting with an ED?	How is the word faith communicated to the client within pastoral care? In your opinion are religious words such as faith helpful or unhelpful in rehabilitation when dealing with those with EDs? Is pastoral care an integral part of faith formation within your church community? If so, how?
External stimulus/ emotions/ behaviour	21. How is the concept of healing used within the context of pastoral care when considering an individual presenting with an ED?	How is the word healing communicated to the client within pastoral care? In your opinion are religious words such as healing helpful or unhelpful in rehabilitation when dealing with those with EDs?

External stimulus/ emotions/ behaviour	22. How much is your church informed by secular methods from psychology, social work or psychiatry within the practice of pastoral care to women with EDs?	Do you think the church should or should not use secular sources to develop methods of pastoral care? Are there any theological restrictions or concerns in your opinion when using therapeutic methods such as CBT, mindfulness based therapy, DBT or psychotherapy?
External stimulus/ emotions/ behaviour	23. Do you believe the network of carers use in Church based pastoral care should have a Christian faith to be effective in care?	If so is there specific characteristics of their faith which would deem them a suitable pastoral carer? How is their suitability as a pastoral carer measured?
External stimulus/ emotions/ behaviour	24. Would it be helpful to use more secular methods in replication of the health service or should the care offered by the church be distinctly different?	If so could you document the aspects of pastoral care within church which offer a distinctly different form of care? Are there any means by which this could be improved in your opinion? How would you describe your church's ability to care for a woman with an ED?
Conclusion of Interview	25. Thank you for your time. Do you have any questions that you would like to ask of me?	

Appendix 14

Pseudonyms and brief descriptions of those claiming insight

Aaron - Methodist minister, psychotherapist and counsellor.

Anne-Marie – Chief Executive Officer of a women's charity with spirituality as ethos and former Roman Catholic church attendee.

Carole - Lecturer in Christian education throughout NI, church attendee and has personally experienced an ED.

Cathy - Manager and counsellor for a Christian women's refuge for those experiencing addictions and member of a charismatic church.

Charles - Psychiatrist, lecturer in psychiatry, author and involved in leadership of a Baptist church.

Christine - Roman-catholic church attendee working as a counsellor in a community-based women's charity with those experiencing distress and presenting with various mental health issues including EDs.

David - Lecturer in social work, specialising in mental health and former member of PCI.

Frances - Lecturer in nursing and retired PCI's minister's wife.

Graham - Consultant psychiatrist specialising in EDs, author, Christian conference speaker and attendee of a charismatic church.

Harvey - Retired medical consultant and former leader and planter of a charismatic church.

Jean - Lecturer in nursing and pastoral counsellor in and attendee of a charismatic church.

Lesley - Psychotherapist and MBI specialist currently working with those experiencing EDs, hosts inter-faith retreats and former nun in a roman-catholic convent.

Samantha - Former PCI missionary, PCI attendee and lecturer in social sciences.

Samuel - Psychiatrist, Presbyterian elder, Christian conference speaker and lay preacher.

Sinead – Co-ordinates counselling service in the board of social witness for a Protestant denomination.

Siobhan - Former lecturer in theology, Baptist church attendee and former founder and chair of a Christian charity for young people experiencing mental health issues.

Appendix 15

Participant Information

What is the area of exploration?

This research encompasses a practical theological exploration into the lives of females with eating disorders. This aim is to gather information regarding the perceptions of care in church communities in Northern Ireland.

What is the background to this research?

The number of women with recorded eating disorders is increasing in Northern Ireland, the urgency for effective treatment is apparent. When considering that Northern Ireland is statistically the most religious province in the United Kingdom, this research project seeks to discover whether involvement in church community has any influencing factors in the life story of women experiencing eating disorders. Through this exploration the aim is to provide helpful research findings which could be used as a bridge to more effective care for church communities and health service providers concerning women with eating disorders.

How can I participate in the project?

You will be asked to participate in a semi-structured interview. There will be a series of set questions but also a flexibility to explore issues which seem relevant to the researcher. It will take approximately one hour to complete the interview process. Your participation in the research is not compulsory and you are free to withdraw consent at any time. However, your participation will be invaluable in mapping and planning future service development for care.

Is the information I complete in the questionnaire be treated confidentially?

Yes, all information gathered from the semi-structured interview will be anonymous and stored confidentially.

How will the information that I provide be used?

Information from the interviews will seek to answer questions such as whether religious experiences in Northern Ireland has aided in, or, detracted from, assisting clients with eating disorders. The information collected will be recorded, transcribed and analysed by the researcher.

I have a question about the project who can I contact?

Contact Carolyn Blair on 07912117989 or cblair05@qub.ac.uk

Appendix 16

Consent Form - Participation in semi-structured interviews
Name of Chief Investigator - Carolyn Blair

Please initial

I agree that I have been given and have read and understood the project information sheet for the research study. [ ]

I have asked and received answers to any questions raised. [ ]

I understand that my participation in the project is voluntary and that I am free to withdraw at any time without giving a reason. [ ]

I understand that the researchers will hold all information collected from The interviews will be kept in a secure place and that all efforts will be made to ensure that I cannot be identified as a participant in the study. [ ]

I understand that the qualitative interview will be recorded via two voice recording devices. **However, if I do not wish the interview to be recorded in this manner I understand that written notes will be taken during the interview.** [ ]

I agree to take part in the interview

Name of subject_____ **Signature**_____ **Date**_____

Appendix 17

Researcher bias

In order to attain validity in qualitative data collection and analysis, Crewell and Miller (2000, p.127) recommend that "it is particularly important for researchers to acknowledge and describe their entering beliefs and biases early in the research process to allow readers to understand their positions and then to bracket or suspend those researcher biases as the study proceeds." Similarly, Ogden (in Given, 2008, p.61) suggests that "social scientists should acknowledge their own subjectivity in the research process." Therefore, it was necessary to acknowledge my positionality as a researcher to both myself and my supervisors in order to ensure an unbiased analysis, as far as possible. With the help of my supervisors, I have been acutely sensitive to the potential for the projection of my personal experiences onto the narratives in both the interviews and the analysis of the data. As an interviewer who has experience of working in a Presbyterian church community in NI, I have practical insight into pastoral care, as well as pre-formed perceptions of the care of those with mental health issues in such communities. Furthermore, I have a personal experience of an ED, therefore I have insight into the gaps in service provision and thoughts on how this could change to benefit those experiencing EDs and their carers. During data collection and analysis, I was aware that it is extremely important to be vigilant concerning biases which could affect the validity of the study, therefore ongoing self-reflexivity has been vital in the data collection and data analysis. Disclosing to the interviewees that I had experience of an ED increased the feelings of safety and authenticity in the interview dynamic, thereby facilitating the collection of very rich data. Acknowledging my positionality regarding my beliefs about the inadequacy of pastoral care in church communities in NI with my supervisors, has permitted more informed assessments of the integrity and validity of my research.

During data analysis I frequently reflected on the possible impacts of underlying perceptions caused by my own experience, including empathy with the women who had experienced EDs, which could lead to over-interpretation of what was reported (or not reported). The practice of self-reflexivity and self-awareness during data analysis, diminished the risk of bias. It is recognised, however, that although total impartiality and integrity have been my aspiration, in this type of research there is often a reflection of the perception of the researcher in the

analysis. I have made every attempt to capture the identity constructions of the collective voice of interviewees through the data analysis. In an effort to guard against potential errors, subjective interpretation and my personal biases, my supervisory team have acted as secondary raters to cross-check emerging themes and elements that emerged from the data. A second check of the data analysis categorisation process has increased the validity of the data (Burnard, 1991). While my decision-making has been trusted throughout the process, this method of peer-checking has been used as a means to provide rigour to the qualitative data analysis and reduce the impact of subjective bias (Rolfe, 2006). Therefore, despite my own passionate views concerning the areas of this thesis, I was self-reflexive and throughout, aspiring throughout to achieve the utmost research integrity recognising the necessity to be objective to attain research validity.

Appendix 18

Vulnerability

Contributions to practical theology

A natural human reaction is to attempt to avoid suffering when one does not feel safe. The automated system as evidenced by the body's dissociative capacity, is the body's defence system and method of emergency. Although dissociation temporarily protects the psyche from traumatic experiences which are too unbearable to integrate, this causes splitting and fragmentation (Kalsched, 2012). This fragmentation often causes a hyper reactivity and increased feelings of threat, especially when certain stimuli reminding the individual of the trauma appears in their environment (Herman, 1992; van der Kolk, 2012; Kalsched, 2013). Consequently, this decreases one's ability to 'sense' with accuracy and distorts one's internal compass which ultimately contributes to compounded traumatic experiences (van der Kolk, 2012). An inability to trust often causes a withdrawal from relationships for the one who has experienced trauma; this causes an isolation which persists and deepens the complexity of the difficulty (Herman, 1992). In such circumstances, the development of healthy boundaries in care is important to help the individual recovering from an ED to feel contained and safe and are essential to establish in the initial stages of pastoral care (Jung, 1939; Winnicott, 1971). If the carer manages to create a safe holding environment, the individual's 'true self' could emerge (Rothschild, 2004). Therefore, listening without conditionality while letting go of judgement is vitally important (Rogers, 1951). When genuine empathy and compassion are engaged, those who have experienced suffering are presented with the opportunity to feel contained. Consequently, the journey of navigating through one's emotions can commence (Winnicott, 1971).

Appendix 19

Power

Contributions to practical theology

When a woman has unresolved trauma, splitting occurs as she regresses to the paranoid and schizoid stages of development (Klein, 1946). As 'the self' and 'the other' emerge, this leads to the well-known phenomenon in which she sees herself as 'all good' or 'all bad' (Klein, 1946). Augsburger (1996, p.63) explains that the wounded individual carries the "unowned, unacceptable parts of the self." He (1996, p.63) continues, "[a]s we see these traits in the face of the foe, projections though they are, they disappear in the self." As the projections become concretised in the face of 'the other,' the self becomes the image of the child who has not been heard and 'the other' is the figure of power. When unable to see the internal dynamics, and with the propensity to psychologically project, the individual will inevitably repeat the past and recurrently find themselves in circumstances of unhealthy power dynamics in their outer reality (van der Kolk, 2014). Aided by contributions from object relation theory, individuals can become aware of the 'bad objects' within themselves and 'bad objects' in others become less difficult to comprehend and manage (Klein, 1946). In order to maturely resolve issues in one's external world, one must be committed to first becoming aware of the internal process which causes repeated feelings of oppression. As awareness is brought to the feelings of oppression that are prevalent in the internal and perceived external world, it is possible to more readily recognise self-created power structures based on their presenting past (Jacobs, 2012). This awareness is the first step of liberation as the journey of recognising patterns of submission, subservience and people-pleasing behaviour commences.

Appendix 20

Embodiment

Contributions to practical theology

In accord with polyvagal theory, Levine (2010, p.111) suggests that "[t]o the degree that traumatized people are dominated by shutdown, they are physiologically unavailable for face-to-face contact and the calming sharing of feelings and attachment." As traumatic experiences usually decrease an individual's ability to receive and integrate empathy, at this point disconnection through dissociation often occurs causing a sense of disembodiment. This dualism permits an emotional detachment which temporarily protects the psyche from unbearable pain. However, this consequently causes a sociological detachment which impairs one's capacity to form meaningful relationships (Şar and Öztürk, 2007). Security in attachments provides not only a sense of personal safety but also a secure base for healthy exploration (Strenger, Schnitker and Felke, 2016), while impairment of this capacity has devastating consequences on human flourishing and the development of the imagination. Therefore, when considering issues of embodiment it is also important to address attachment issues in those experiencing EDs.

Engaging with one's emotions permits the ability to live a full healthy life; conversely, numbness diminishes one's ability to feel positive emotions and experiences. There is no method of selectively numbing some emotions and not others, therefore, although this is an effective way of diminishing pain, it also diminishes pleasure (Damasio, 2003). When one ceases to repress traumatic experiences, the metabolisation of this inevitably causes the emergence of strong and sometimes uncontrollable emotions (Ford et al., 2015; Kalsched, 2014). Emotions are somatically felt; they motivate behaviour and they have energy and power that need to be expressed and regulated. When referring to the consequences of excessive feelings of fear, Damasio (2003, p.40) explains "… some emotions are terrible advisors" therefore it is important to consider how to "… reduce the consequences of their advice." Consequently, cultivating skills of distress tolerance and deliberately slowing down

responses, can establish an ability to accurately sense, rather than being compelled to behave in response to, strong emotions and ultimately change one's life trajectory. Furthermore, Bechara, Damasio and Damasio (2000, p.1) emphasise the importance of the ability to interpret one's 'senses' in decision-making; they emphasise the role of the biomechanics of the body connected to the emotions, such as the association of rapid heartbeat with anxiety or of nausea with disgust. Drawing attention to bodily based reactions to stimuli is therefore of the utmost importance in establishing a healthy relationship with one's emotions. Furthermore, Neff's (2003) suggests a change in language use; from self-esteem to self-compassion alongside mindfulness-based therapy and compassion-focused therapy are among the most important factors in emotion regulation (as supported by Siegel, 2015; Gilbert, 2014). As meditation is used in secular fields to help regulate emotions through building capacity in distress tolerance, this points towards the Christian contemplative tradition as a potential aid to those experiencing EDs.

Appendix 21

Creativity

Contributions to practical theology

When an individual experiences trauma, their imaginative capacity is often debilitated, with a multiplicity of consequences including fragmentation linked to a process of "fantasying" (Winnicott, 1965). Winnicott described "fantasying" as a morose depressive state which is a defensive use of the imagination used in an effort to escape an unbearable reality. However, when one feels safe, the true self, which has the capacity to live creatively, can emerge, which also strengthens the ego identity and makes further creative potential more easily accessible (Elliott, 2002). The capacity to use one's imagination requires a healthy worldview shift and is possible when the transitional space is reopened. The process of using metaphor and telling narratives can reopen the transitional space, provide a link between the two worlds of spirit and matter and cause moments of insight which act as a cultivator of imaginative capacity. When these links are re-established, the soul comes to dwell in the "space between the worlds" (Kalsched, 2014). As interaction with the imagination creates narratives and metaphorical themes in which one can place themselves, one can assess options and integrate results concerning the images which emerge. Schwartz (2013, p.199) explains that creative methods such as, "[s]torytelling, myths, artistic expressions, humour, paradox and metaphor may be the only ways to reach and negotiate with the calcified, dissociative aspects of some patients." Therefore, through creatively intertwining the narrative of the individual who has experienced an ED with the divine narrative through the imaginative capacity, this could have a contextualising effect and could open a sense of central coherence in a way which may not have been accessible in the past.

Opening the transitional space as described by Winnicott (1971) is of vital importance to access the imagination. Kalsched (2013) is adamant that the quality of the therapeutic relationship itself is of paramount importance in opening this space. He (2013, pp.19-20) explains, "[s]uch a relationship holds the hope that both inner and outer transitional space may open once again, that connections in the brain can be slowly re-wired, and that

archetypal defenses will release us into human inter-subjectivity and ensouled living." When the transitional space (Winnicott, 1971) is open, this provides a pathway for creativity and play for the good use of the imagination. In this transitional space one moves from the internally constructed world of fantasy to the outer world of reality.

Appendix 22

A feminist interpretation of John 20:11-18

Introduction

In a feminist reconstruction of John 20:11-18 Mary Magdalene becomes an icon of female identity, divinely tasked to take her stand as an equal in a highly patriarchal social system. As a figurehead for the liberation of women, Mary becomes a messenger of hope for women in contemporary society, Shaberg (2006, p.152) explains "it seems Mary's story is once again a popular place for thinking about religion, the church, women and men, and the body". However, it is notable that a re-construction of John 20:11-18 and other passages where Mary Magdalene appears is part of a "much larger discussion" about patriarchal oppression and women's journeys in flourishing and overcoming (Shaberg, 2006, p.152). As Fiorenza (1992) and Jones (2002) suggest, a re-construction and a diversion from traditional historical interpretations is thus necessary to provide meaning for women who have been oppressed. However, when considering a traditional historical interpretation, this also can be useful in exposing the patriarchal oppression that surrounded Mary Magdalene and highlights her tenacity and ability to overcome barriers erected by a male-dominated society. Through a feminist interpretation of John 20:11-18 this reconstruction will explore: the darkness of suffering, the transformation from pain to joy, the commissioning of a voice and a new beginning. For women who have experienced EDs and struggled with feelings of low self-worth, subservience and the suppression of their voice, Mary Magdalene's encounter in John 20:11-18 can be the catalyst for renewed hope.

Methodological approach

As patriarchal edifices marginalise and oppress women it is not surprising that both historically and in contemporary society female power appears diminished. Fiorenza's (1992, p.93) feminist historical reconstruction helps to deconstruct the "androcentric reconstructions of ... Christianity's origins that marginalize or eliminate women and other non-persons from the historical record". Therefore, in the absence of this "pyramidal system and hierarchical structure of society and church" (Fiorenza, 1984, p.5) the meaning of John

20:11-18 in regard to Jesus's relationship with women, in particular Mary Magdalene, will become more visible and potentially helpful for women who have themselves felt marginalised, vulnerable and disempowered. As liberation theology advocates the empowerment of the oppressed this requires transparent advocacy to stand against the passivity (often described as objectivity) that traditional biblical commentators often demonstrate (Fiorenza, 1992). However, when approaching John 20:11-18 from Fiorenza's (1992) perspective of historical reconstruction, the priority is not historical accuracy but rather is to reconstruct the centrality of Mary Magdalene's role within the Christian tradition and thereby bring a voice of hope and potential liberation to those who have experienced EDs. Fiorenza's (1992) historical reconstruction is applied practically by Jones's (2000, p.55) feminist critical lens wherein doctrine is re-formulated using the imagination of the onlooker. Considering that a commendation of oppression and liberation cannot co-exist, Jones (2002, p.56) explains "It is for this very reason that doctrine is re-imagined at every instance of it being read". Through a sense of deep identification with the narrative of Mary Magdalene at the tomb, Jones's (2002, p.56) approach can help to ignite the imagination "where oppression has disrupted it". This process of re-imagining occurs through the re-interpretation of John 20:11-18 and provides "a dramatically different ending to the trauma and suffering known by its onlookers" (Jones, 2002, p.124). This approach is significantly important when considering that women experiencing EDs often fear the future and cannot see an end to their suffering, therefore relief in the present is often their primary focus. Alternatively, this approach provides a different vantage point, a different meaning to endings and ultimately a different vision for the future.

The darkness of suffering

In Mark's account (16:1), and Luke's (24:1), the women come to the tomb to anoint Jesus' body but, in John 20:11-18 there is no explicit reason given why Mary came to the tomb. However, the reader is told that, when Simon Peter and the other disciple depart, Mary is left standing, weeping at the tomb, in the "darkness of unbelief" (Moloney, 1998, p.525). Mary's weeping expresses her deep sense of loss because of Jesus' death, intensified by her expectation being thwarted when she finds the tomb empty. This reality deepens her

disturbance as she does not understand what has happened (Kelly and Moloney, 2003). This sense of the deepening of grief when Mary encounters the emptiness of the tomb is a useful parallel to draw with women experiencing EDs. Their emotional emptiness, experienced even during recovery, is often so intense that it increases rigidity and as discussed on pp.172-176 can be associated with weak central coherence which causes polarity in their thought processes. As described on pp. 172-176 this rigidity often increased through feelings of emptiness and a deep sense of loneliness is a major contributor to why so many suffer frequent relapses. Mary wants to understand what has happened, similar to many women who are actively wanting to recover. However, for Mary, there is a desire to understand evident by her courage in looking into the tomb, yet there is symbolism in the fact that Jesus is not found in this place of death, but rather he is found in the garden, a place of flourishing, new life and growth. It is notable that despite searching the wrong place, Mary encounters the angels. Considering the appearance of angels is a sign of the presence of God, this is significant and would suggest that amidst the depths of pain and even in looking to the place of death for answers God wanted Mary to know He was with her. It is notable that Mary is given the privilege of encountering the angels, unlike the other two disciples, so this again underscores Mary Magdalene's importance in the gospel narrative. As the angels ask Mary why she is weeping, she responds "They have taken my Lord away... and I don't know where they have put him" (John 20:13), in reflection of this experience the reader is informed she is not afraid. There is a certain power in vulnerability exhibited by Mary's fearlessness as Mary's passionate love for Jesus is the catalyst for her persistence and determination in her search for Jesus. This is particularly important as fear is the common response to the presence of angels (Luke 24:5, Mark 16:6 and Matt 28:5). As fear and feelings of emptiness are two of the most debilitating emotions felt by those experiencing EDs, Mary's courage in the depths of her distress is demonstrated by her entrance into the tomb. However, by Mary's entrance into the tomb there are parallels with looking to the past for answers to the present, which is understandable, nevertheless it is evident that dwelling in this place does not bring joy. As described on p.135 for many of those experiencing EDs there has been a necessary reflection on the past however for those who have recovered there is a hesitancy to go back to this place as it is associated with pain and stagnancy. This reminder of the immanence of God is a further assurance to those who trying to find answers for their present suffering that God will be with them. Furthermore, this is also a signifier that the place of hope comes not from

looking to the past but rather in moving into a new milieu, albeit with uncertainty and ultimately is an encouragement to expect the unexpected from God.

The transformation from pain to joy

Mary Magdalene is the first to see the risen Jesus, however the reader is told, "As she said this she turned round and saw Jesus standing there, though she did not recognise him" (John 20:14). Although there are alternative views as to why John presents her confusion as significant, it would seem feasible that recognition of that which has been promised cannot be perceived in an instant (Moloney and Harrington, 1998, p.525). As Bruner (2012, p.1151) states, Mary's incomprehension can be explained by the "simple fact that one does not expect to be talking to a resurrected person." This non-recognition aspect of post resurrection appearances is common to the gospel accounts where the emphasis is on the unexpected nature of such appearances (Luke 7:11–17; Luke 8:49–56; John 11:1-44). This sense of embracing the unexpected and resting with unfamiliar emotions associated with uncertainty is again a crucial factor in the recovery of women experiencing EDs as their lives have often been consumed by the need to control outcomes.

When what the person she believes to be the gardener speaks to Mary, her distress is apparent, Jesus uses the same words as the angels, "Woman, why are you weeping?" (20:15). Mary's distress is evident until she realises that it is Jesus' voice then "She turned and said to him in Hebrew, "Rabbouni!" (which means Teacher)." Bennema, explains (2009, p.197) that the repetition of the question to Mary indicates that Jesus alone as the "Revealer has the privilege of resolving Mary's problem." The fact that the reader is told Mary "turned", signifies a transformation from the depths of pain to the heights of joy as Mary sees Jesus through the eyes of faith, Mary thus experiences a personal resurrection herself. The "turning" in this encounter is reflective of many of the women's narratives who can recall a monumental day when they decided that they were commencing the journey of recovery. The encouragement in this encounter between Mary and Jesus is that the moment she "turned" Jesus was with her, the presence of God incarnate met her at the point of her deepest despair. The joy which is inherent in this unexpected outcome for Mary is again another assurance that women can

rest in the certainty of God fulfilling his promises but yet also emphasises the need to take decisive action to be open to possibility. As we have seen on pp.183-187 although closed-mindedness and rigidity provide a pseudo-sense of safety these characteristics close the door to fulfilment and authentic faith which is a pathway to personal flourishing and creativity. Although the joy of encountering the risen Jesus with the eyes of faith is apparent, Moltmann (2004) is careful to retain a sense of the endurance of both sorrow and joy albeit in a transformed manner. Moltmann (2004, p.162) explains "Even wounds that have healed can still be seen from the scars they have left, though they no longer hurt. Even if the tears of grief are wiped away and the grief has been turned into joy, the eyes are still wet." It is important that when feelings associated with grief are felt by those experiencing EDs that this is not diminished, and the carer should be careful not to fast-track this process but rather this natural stage should be viewed as the catalyst for transformation.

The commissioning of a voice

As Mary is endowed with the honour of being the first to encounter the resurrected Jesus, this could be deemed the apex of a feminist interpretation of the gospel narrative. When considering that the context of John 20:11-18 as one of the most significant personal interactions with Jesus after his resurrection, is situated alongside the narratives with Peter (John 21:1-19) and Thomas (John 20:24–29), there is also a further message being conveyed. Each of these interactions, in differing ways, communicate a message of restoration, filled with an assurance that Jesus met individuals where they were, overlooked their weaknesses and commissioned them to commence on a trajectory of authentic faith. As Bourgeault (2010, p.10) explains, Mary Magdalene was "not only the first witness to the resurrection, but the first to express her faith by announcing it publicly. In two of the four gospels this is a charge to which she is specifically commissioned by Jesus himself". The radical nature of Jesus is evident within the context of this commissioning as given the patriarchal context, this is pregnant with an implicit meaning pointing to the necessary empowerment of women (Keller, 2008).

This moment of transformation was a momentous timepoint in history, Bruner (2012, p.1152) explains that Mary was the first person be fully present when human history took a turn to a responsible hope for the vincibility of death and, so, to the conquest of meaninglessness." At

the point Mary "turned", there is radical transformation and the significance of the commissioning commenced once Mary's name is called. As names in the ancient Israel revealed identity, significance and relationship, the fact that Jesus called Mary by name is particularly important. Mary responds with "Teacher". Lee (2002, p.223) explains they "anointed each other with their names." This is particularly noteworthy as other gospel writers refer to Mary Magdalene as "the woman", as opposed to bearing the significance of having a name. Furthermore, when considering the context and Jesus' deliberate naming of Mary, ancient patriarchal agendas such as namelessness or women's names being used in conjunction with their husband or father are contested. The divinely mandated empowerment of women speaks directly to the experience of low self-esteem and feelings of worthlessness which featured in all of the interviews with women who experienced EDs. As Mary Magdalene, deemed a woman with no social standing, was commissioned by God to share the most important news in biblical history, this directly impacts the value women are deemed to possess in both matters of trustworthiness and standing. Therefore, for women experiencing EDs this is an encouragement to trust in their own competency and helps to counteract the propensity to subservience and voicelessness which often manifest as inherent characteristics associated with the disorder.

A new beginning

Mary is described as reaching out to Jesus and his response is "Do not hold on to me" (NRSV) or "Do not cling to me" (NJB) or "Stop holding on to me" (NABRE). The translation of this particular phrase is problematic and has resulted in some patriarchal interpretations including Origen's suggestion that Christ did not want to be polluted by Mary prior his exaltation. The present tense of the imperative provides a different interpretation, which Lee notes (2002, p.225) as "the sense of the ongoing aspect: literally, "do not go on touching me." The difficulty is not that Jesus is rejecting physical contact with Mary but rather that she must "not hold onto him" because the time has come for a new beginning, a resurrected life, empowered by the Holy Spirit (Lee, 2002, p.225). This has significance for women experiencing EDs as many seem unable to progress forward and are locked in a tormenting negative cycle of obsession with that which has passed. Therefore, this phrase bears particular significance considering

that opening the doors to future possibility requires a necessary letting go of that which has passed and embracing a new phase of life. This also has significance for caregivers in that there is a time for being fully present in constant contact with the sufferer but also a time to reaffirm the self-empowerment which is inherent to the woman in recovery. The mutuality of this phase of letting go to encourage individuation rather than a vulnerable dependency is mirrored in Mary's interaction with Jesus.

However, it is also important to note that Jesus tells Mary that he is "ascending to my Father and your Father, to my God and your God." This sense of personal belonging is apparent through the emphasis on "your", indicating that this is a new covenantal relationship reminiscent of Jer. 31:33; Ezek. 37:28 and Ruth 1:16. This sense of belonging twinned with identity is again another crucial factor for those experiencing EDs. The theme of identity is important to understand in care contexts, as when an individual's story is changing, their identity is also symbiotically changing. When overwhelmed by one's present suffering, it is evident from the interviews with women experiencing EDs that establishing identity is difficult. Therefore, embracing the covenantal bond with God, the Father is filled with hope and can redirect the suffering individual's life by providing a stable underpinning narrative. Identity is formed through relationships, and a mirroring of the relationship between Mary Magdalene and Jesus gives hope that the relationship which Mary witnessed Jesus having with His father is now open to all. Moving to a place of comprehension, meaning and transformative power can occur when individuals' lives becomes intertwined with the divine narrative. By sensing the intimacy that comes through connection with others, the liberation and joy that comes through trusting and being trusted builds confidence, assurance of acceptance and purpose and diminishes the feelings associated with loneliness.

Conclusion

As Mary suffers amidst the grief in the perceived loss of Jesus, there is a distinctive similarity to women experiencing EDs, as the pain and hopelessness she encounters are palpable and evidenced by her behaviour. The depths of pain are therefore not to be diminished but rather viewed as a necessary part of the transformative experience. Stuart (2000, p.166) notes,

“Therefore, the beliefs that the resurrection involves some kind of bodily change and that bodies continue to bear the scars of human contingency are not necessarily incompatible. Indeed, they are mysteriously connected.” Through twinning the purposefulness of the discomfort of the past and the creative progression into a new form of life births new meaning for those who have lived with this dissonance. As Mary “turned” this signified her behavioural progression into a new form of life, yet the pain of loss was the catalyst for this stage of life which signifies that there is a connection. This perspective respects the brutal injustice of suffering, remembering the scars, but yet also provides a material hope, evidenced by the physical resurrection. As Jesus emphasises that Mary must not “hold onto” him, this does not diminish the focus on the body, but rather draws the attention back to Mary being empowered to live differently with a new sense of joy. This process is indicative of a resurrection in Mary’s journey, although the pain she suffered was a natural and appropriate response to perceived loss, the imminence of a new beginning is emphasised as the pathway to continues growth. For women experiencing EDs, this is important as the focus is not diminishing the horror of past traumatic experiences but rather is on the transformative possibility through these experiences. Furthermore, it is the loving presence of the living Christ who made himself known and commissioned Mary’s purpose in her unique and highly significant experience. By consequence Mary’s narrative could inspire generations of women to know that the resurrection narrative symbolises not only the power of God but also the possibility of a new hope, a new commissioning and a new sense of their intrinsic worth. Fiorenza (1992) asserts that Mary’s experience signifies a ‘discipleship of equals’, which reconstructs Mary as a truly trustworthy leader and authoritative disciple of Jesus. Furthermore, given the patriarchal restrictions of ancient Israel, Mary was an iconoclast and is a role model for women experiencing EDs to truly know the empowerment that can come through a personal resurrection.

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